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General Practitioners' perceptions of mental health services and factors influencing their referral decisions: a comparative, qualitative study.

^{LEE}
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Submitted in partial fulfilment of the requirements for the degree of
DOCTORATE OF CLINICAL PSYCHOLOGY

CLINICAL PSYCHOLOGY
SALOMOMS CENTRE
ACCREDITED INSTITUTION OF THE OPEN UNIVERSITY

Date of award: 11th September 1996

SEPTEMBER 1996

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed *Richard Maddrell* (candidate)

Date *12th July 1996*

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Signed *Margie Callanan* (supervisor)

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I dedicate this research to Karen for an incalculable amount of support and encouragement.

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ABSTRACT

This study provides a rationale for using a qualitative methodology to explore the factors which influence the GP to refer patients to mental health services. Referral data for a 12 month period were collected and a semi-structured interview used with five male and five female GPs. Findings indicated the importance of inaccessibility in influencing how mental health services were used and suggested that GPs adopt different strategies to manage difficulties associated with this. Clinical psychologists were perceived as inaccessible by all participants whilst their role was generally defined in a very limited way, with reference to behavioural management skills. In-practice mental health professionals were used extensively and valued due to ease of access, increased opportunities for direct communication and reduced stigma for the patient. Comparative analysis suggested that, generally, female GPs placed more emphasis on the doctor-patient relationship and there was an increased likelihood of the female GP perceiving the management of mental health problems as part of their role. Further research questions are considered and methodological issues addressed. The implications of the findings for the relationship between clinical psychology and general practice are discussed.

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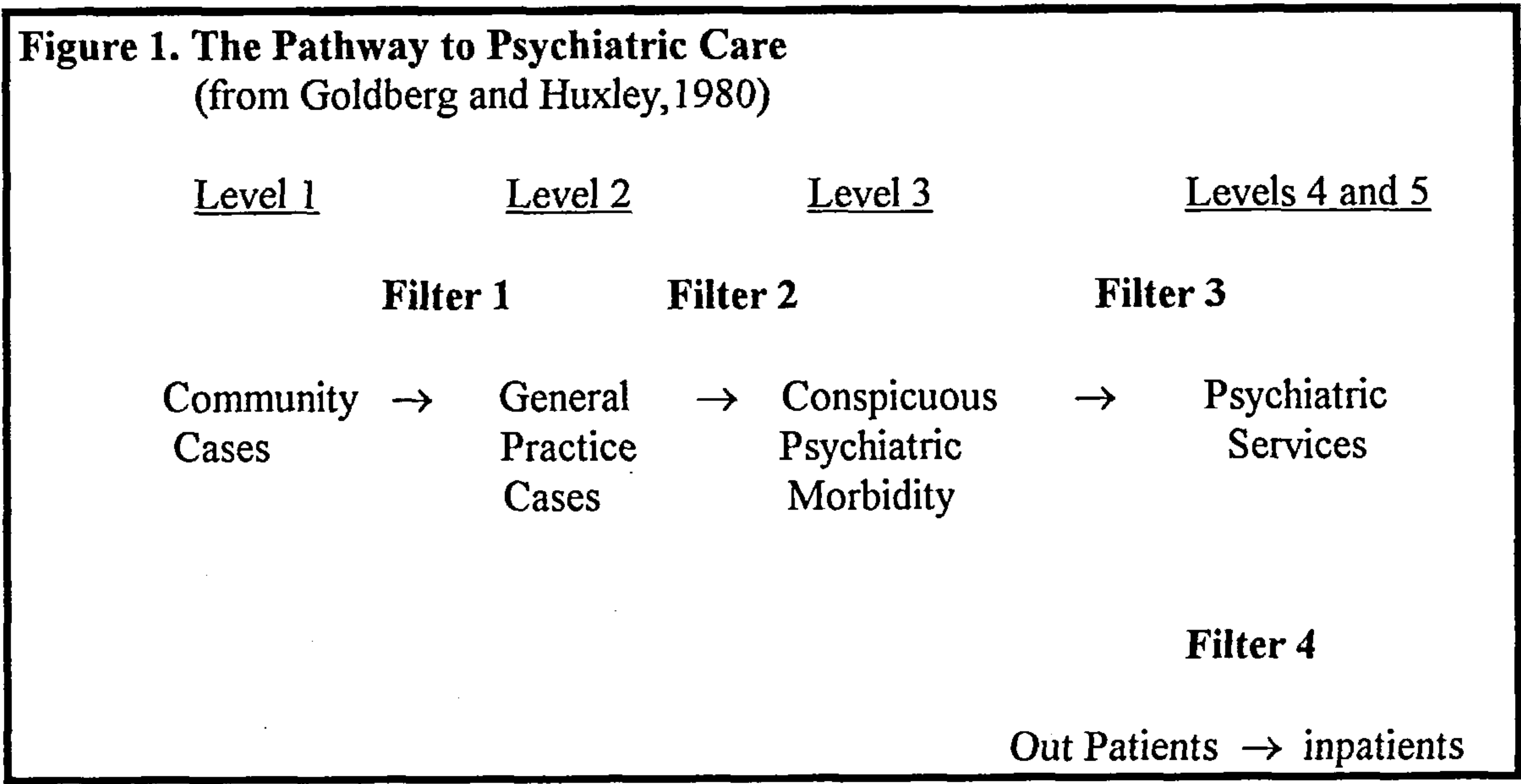
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1. INTRODUCTION

1.1. General Practitioners and mental health problems

The process of accessing mental health services can be understood in terms of a ‘levels and filters’ model (Goldberg and Huxley,1980). As Figure 1 shows, in order to pass from one level to another the individual must pass through a selectively permeable filter. In the context of this model the General Practitioner constitutes the gatekeeper to secondary care, controlling filters 2 and 3, and consequently controlling the number of community cases reaching psychiatric services. Goldberg and Huxley (1980) estimated that because of this filter, for every 250 people with a psychiatric disorder



in the community (i.e. at level 1), only 17 will access psychiatric services. Their work served to underline the key role played by the General Practitioner in detecting mental health problems and deciding whether a patient’s problem will be managed at the primary care level or whether it requires referral to specialist mental health services.

1.2. GPs' detection of mental health problems and referrals to mental health services

Early work in this area sought to address the factors influencing GPs' sensitivity to, and detection of, psychological distress. These studies revealed wide variations in GPs' detection rates (Goldberg and Kessel, 1975). In exploring these variations, Marks, Goldberg and Hillier (1979) observed over 2,000 GP consultations. They identified that the GP's level of interest in psychiatric issues and empathy during the consultation were important variables in determining the GP's detection of psychiatric disturbance, as measured by the General Health Questionnaire (Goldberg, 1979).

The notion of consultation style has been of interest to researchers since the 1970's. Byrne and Long's (1976) study of the verbal behaviour of GPs during the consultation suggested that certain types of behaviour, such as listening or reflecting, could be considered representative of a patient-centred consultation style. In contrast, a doctor-centred consultation style was characterised by analysing, probing and information gathering. The authors concluded that GPs rarely altered their style. Whilst others have questioned the immutability of consultation style (Neighbour, 1987), it is possible that this factor is an important influence on GPs' ability to detect psychological problems.

More recent research has suggested that the gender of the GP may influence consultation style (Bensing, Van der Brink Muinen and de Bakker, 1993). Bensing et al. (1993) studied 23 female and 27 male GPs and collected data on over 47,000 consultations. Participant female GPs spent more time on their patients and had a

stronger tendency to provide continuity of care. Their findings also suggested that female GPs see different problems from their male colleagues; these included certain health difficulties, such as gynaecological problems, but also social problems. If female GPs approach patients' difficulties differently to their male colleagues, it may be that their detection of psychological problems and the process by which they come to refer patients to mental health services is also different.

Whilst the rate at which psychiatric disorder is detected by individual GPs is likely to vary, research suggests that, once detected, GPs manage the majority of these cases without using secondary services. Shepherd, Cooper, Brown and Karlton (1966) identified the large discrepancy between the number of psychological problems presented to the general practitioner and numbers referred to psychiatric services.

Shepherd et al. (1966) studied 46 London practices over a one year period and their findings indicated that the majority of GPs in their sample considered the treatment of minor psychiatric disturbance as part of their role. However, the treatment offered was often 'haphazard and inadequate' (p175).

Research has sought to explicate the factors which may influence the GPs decision to refer patients to mental health services. Robertson (1979) used postal questionnaires and interviews to access 147 GPs in both rural and urban settings. Her findings suggested that firstly, doctors in urban practices refer more frequently and, secondly, suicidal gestures and high levels of drug and alcohol abuse increased the likelihood of referral. The first of these findings has been re-affirmed by subsequent research (Verhaak, 1993), and Robertson (1979) suggests that it may be explained by the extent to which GPs in rural areas are forced to treat more cases of psychiatric disorder due

to difficulties accessing services. The second finding suggests that patient characteristics play an important role in the GP's decision to refer. Subsequent research has suggested that GPs are more likely to refer those patients with high levels of social impairment and behavioural difficulties (Munk-Jorgensen, 1986).

More recently, Verhaak (1993) studied 161 Dutch GPs, collecting details of all contacts with patients over a three month period, including diagnosis, treatment and referral. Participants also completed a questionnaire including questions regarding their perceptions of mental health care tasks. His analysis indicated two pertinent findings. Firstly, only six per cent of patients presenting to their GP with a psychiatric disorder were referred to secondary services. This lends support to Shepherd et al.'s (1966) earlier findings, underlining the large amount of psychological work taken on by GPs. Secondly, doctors with a limited task perception regarding mental health problems tended to refer to mental health services more often.

The principal strength of Verhaak's (1993) study was the stratified sample of GPs used. This included GPs from a variety of different practices from all regions of the Netherlands. However, the generalisability of these findings to the UK is questionable. Variability in the nature and availability of mental health services in the two countries is an important issue whilst cultural differences regarding the role of the GP may also exist.

1.3. GPs' referrals and discrimination between different mental health professionals

The recent growth of community mental services has meant that GPs have a wider range of referral options. The research exploring General Practitioners' perceptions of

different mental health professionals per se is scarce, and researchers have tended to focus on GP referrals to various professionals. Some researchers have sought to identify whether GPs' referral patterns to different mental health professionals are consistent. Wise, Mann, Berlin and Berenbaum (1984) found that in the USA family doctors would refer a variety of problems with equal readiness to psychologists, psychiatrists and social workers. However, in the UK, Bouras and Tufnell (1983) have shown that GPs make referral decisions on the basis of certain patient characteristics: unemployed patients or those with a previous in-patient history were more likely to be referred to a local crisis intervention team. Further research has indicated that patients with high levels of behavioural disturbance and social difficulties were more likely to be referred to an outpatients clinic by their GP (Kaeser and Cooper, 1971; Revell and Weinman, 1988).

More recently, Gordon (1987) utilised a set of ten hypothetical 'cases' and found a 'fairly close level of agreement' between 101 GPs in relation to who they would refer the difficulty to. However, mental health professionals involved in the study did not agree with the GPs' hypothetical referral decisions, suggesting a mismatch between GPs' perceptions of different mental health professionals and the professionals' own perceptions regarding the type of patient difficulty they are most effective with. Gordon's work thus suggested that GPs' perceptions may be based upon inaccurate beliefs regarding different mental health professionals' skills.

Revell and Weinman (1988) studied 57 referrals by 36 GPs to an outpatient psychology clinic, an outpatient psychiatric clinic and a walk in clinic. A questionnaire was sent to all GPs requesting information about each referral, such as nature of the

patient's problem, degree of risk to self and GHQ score. Examination of referral letters suggested that GPs in this sample tended to refer patients perceived as depressed to the psychiatrist and patients perceived to have anxiety problems to the psychologist. However, GPs in this sample seemed to base their referral decision upon the extent to which they considered the patient to be in need of urgent attention rather than upon any judgement of the particular treatment indicated. This observation lends more support to Gordon's (1987) findings that GPs' referrals are not based upon accurate knowledge regarding the skills offered by different mental health professionals.

It has been shown that high or low referral rate is maintained for each GP across diagnostic categories, that is, GPs who refer relatively large numbers of patients to mental health services also refer large numbers to other secondary services (Wilkin and Smith, 1987). However, analysis of referrals to psychiatric services and psychological services in one health service district identified that high and low referring GPs used the two services very differently (Creed, Gowrisunkur, Russell and Kincey, 1990). Creed et al (1990) studied referrals from 45 general practitioners in Manchester to the local psychiatry department and psychology department. Their findings indicated three important outcomes:

- GPs' propensity to refer to the services varied widely even within the same health centre;
- GPs who referred fewest patients to the psychiatric service tended to refer more patients to the psychology service;
- GPs who referred more patients to the psychology service tended to write

more detailed referral letters than GPs referring mostly to the psychiatry service.

Creed et al. (1990) argued that the last point was possibly significant in explaining the reason behind differences in GPs use of the two services. They suggest that GPs referring least to psychiatry showed an increased interest in, and aptitude towards, patients with psychiatric difficulties, reflected in the quality of their referral letters. The authors concluded that GPs referring large numbers of patients to psychiatric services may benefit from further training and guidance with the management of these problems.

Two issues arising from Creed et. al.'s (1990) study require further consideration. Firstly, the authors acknowledge that they were unable to assess the appropriateness of the referrals made by GPs; GPs referring high numbers of patients to the psychology service may have chosen to refer in the light of previous positive experiences of the service, with less consideration of whether the patient's difficulty may be best dealt with by another service. Secondly, the rigorous schedule used to assess referral letters generated interesting issues regarding the process of referral. The authors argue that it may prove productive to 'research more closely the decision making mechanism used by the GP and patient in choosing whether or not a psychiatric or a clinical psychological opinion will be helpful at a particular point in time' (Kincey and Creed, 1991, p12). It is unclear, for example, whether 'external' factors such as practice culture or consultation with colleagues influences if and where a patient is referred.

Since Creed et al.'s (1990) study, political changes to the health care system in UK have begun to impact on the delivery of mental health services at the primary health care level. The NHS and Community Care Act (1990) introduced the distinction between purchasers and providers of health services, enabling the GP to purchase a range of out-patient services. A consequence of this has been a significant increase in the number of mental health professionals, especially counsellors, offering services on-site at health centres and practices (Thomas and Corney, 1992). The potential impact of this trend upon GPs' referral patterns is an important consideration.

Griffiths and Cormack (1993) surveyed GPs from one health district and obtained 136 replies, a response rate of 49 per cent. This represented 81 per cent of all practices in the district and participant GPs did not differ from non-responders in terms of the number of patients they referred to clinical psychology. GPs completed a questionnaire requesting information regarding referrals to mental health professionals. Their survey suggested three important findings:

- the presence of a practice counsellor did not affect the frequency of referral to psychology or other mental health professionals;
- a majority (73%) of respondents stated that the lack of availability of some mental health professionals influenced their referral pattern;
- GPs expressing most interest in working with patients experiencing psychological difficulties tended to refer relatively more to clinical psychology than to a psychiatrist. Less interested GPs were just as likely to want to refer to psychology but also referred relatively large numbers of patients to the psychiatrist.

Griffiths and Cormack's (1993) work generates two important points. Firstly, their outcome confirms the finding that GPs who are more interested in working with mental health problems tend to refer relatively higher numbers of patients to psychology services (Creed et al., 1990). Secondly, their findings suggest that accessibility may influence which mental health professionals is referred to.

Whilst Griffiths and Cormack (1993) reported that the presence of a counsellor did not appear to influence referrals to other mental health professionals, subsequent research has suggested that inaccessibility to secondary services may influence the GP to refer to a practice based counsellor (King, Broster, Lloyd and Horder, 1994). King, Broyster, Lloyd and Horder (1994) studied 24 patients referred to five part-time counsellors based in two large group practices. Using a range of measures including the General Health Questionnaire (Goldberg, 1979), the authors concluded that patients with very high levels of psychological distress were often inappropriately referred to the counsellors. Discussions with participant doctors indicated that limited access to local psychiatric services had been an important consideration in making these referrals. Whilst the generalisability of the study is limited by the smallness of the sample it does raise the issue of how in-practice counsellors are used by GPs with limited access to secondary mental health services.

1.4. GPs' experiences of mental health services.

Another consequence of GPs' power to purchase services has been an increased interest in their attitudes towards and satisfaction with mental health services. Griffiths and Cormack (1993) utilised a 1-5 satisfaction scale in their questionnaire returned by 136 GPs. Responses suggested that GPs were least satisfied with services for alcohol

and drug related problems and adults with emotional/ interpersonal difficulties. Eighty per cent of the sample stated that they would refer more to clinical psychologists given greater availability although not to other professionals given greater availability. As Griffiths and Cormack (1993) note, this suggests that rather than there being an unlimited demand for services, there appears to be a need for more of some services relative to others. More recent surveys of GPs' perceptions of different mental health professionals have indicated that they attribute similar positive qualities of professionalism and training to clinical psychologists as they do to consultant psychiatrists and CPNs (Chadd and Svanberg, 1994). However, unlike these other professionals, clinical psychologists were perceived as inaccessible.

The increase in the number of community mental health teams in recent years (Sayce and Chapman 1988) has meant that many GPs have experienced profound changes in the way in which services are delivered. Warner, Gater, Jackson and Goldberg (1993) compared a group of 10 GPs with access to hospital based mental health services with a group of 10 GPs accessing a new community mental health team. Participating GPs rated 100 consecutive patients for the presence or absence of psychiatric morbidity whilst the General Health Questionnaire was also administered to patients. This procedure was repeated three years later. Warner et al.'s (1993) investigation suggested three principal findings:

- the involvement of the mental health team had no discernible effect on GPs' detection of problems;
- GPs accessing the new mental health team spent significantly less time counselling patients as they perceived the team as a more effective option with the added

advantage of time saving;

- GPs saw the skills of the community psychiatric nurses and social workers as particularly valuable in filling the 'gap' in traditional service provision with regard to patients with neurotic illnesses, severe chronic mental health problems and psycho-social difficulties.

The strength of Warner et al.'s (1993) work is that it clearly demonstrates how a direct contact between a GP and a service may impact on the GP's perceptions and decisions to refer patients to mental health services. This finding confirms that of previous studies (Bennett, 1989; Stansfeld 1991). It also suggests that GPs may consider certain professionals to be especially relevant to the mental health needs of their patients.

1.5. GPs' perceptions and use of clinical psychology services

Research in the early 1980's suggests that much of the impetus to develop clinical psychology services at the primary care level has come from psychologists themselves rather than GPs requesting increased input (Liddell, May, Boyle and Baker, 1981).

Eastman and McPherson (1982) contacted 40 GP's randomly from 10 Area Health Authorities. Their findings indicated that whilst 19 per cent of consulting patients were considered to warrant treatment for a psychological problem, approximately 90 per cent of these patients were dealt with by the GP with a heavy reliance upon psychotropic medication. Moreover, most GPs perceived psychologists as being able to offer a limited therapeutic service to the practice on a part-time basis whilst over one third did not want psychologists operating within their practices.

The above findings suggest that clinical psychologists' perceptions of the relevance of their skills to the primary care setting is not shared by GPs. However, two important issues arise from Eastman and McPherson's (1982) work:

- Firstly, the date of this study must be borne in mind. More recent research appears to contradict their findings, suggesting a demand from GPs for increased psychological input (Wren, 1991; Griffiths and Cormack, 1993). Recent changes to the NHS, including the introduction of the new GP contract in 1990, have led to profound changes to the GP role. This has included greater involvement in the financial management of care, creating extra pressure on the GP's time and resources (Chambers and Belcher, 1993). There is evidence to suggest that these changes have significantly influenced GPs' levels of stress and job satisfaction (Rout and Rout, 1994). Thus, it is possible that GPs are under increasing pressure to use available services for patients experiencing psychological difficulties;

- Secondly, it is unclear what the nature of the GPs' contact with different mental health professionals had been and there is some evidence to suggest that this factor may strongly influence GPs' perceptions. Wren (1991) investigated GPs' satisfaction with clinical psychology attachments at four different practices. Her findings suggested that GPs utilised the service extensively leading to significant waiting lists. Moreover, Blakey, Crawford and Taylor (1991) surveyed 234 GPs with varying levels of contact with psychological services. Their survey suggested that GPs with direct experience of clinical psychology attachments were more likely to acknowledge the potential value of the clinical psychologists' skills in terms of offering a consultative and educational role within the practice. Both studies underline how direct contact between the clinical

psychologist and GP may serve to open up dialogue regarding how psychologists' skills may be most effectively used in the primary care setting.

1.6. Professional issues: the importance of the GP - clinical psychologist relationship

The potential contribution of clinical psychologists' skills to primary care has been emphasised by both major reviews of psychologists' role within the NHS (DHSS Trethowan Report; 1977, Mowbray, 1989). Whilst comprehensive reviews of the growth of primary care psychology can be found elsewhere (Wren, 1991) it is generally considered that the development has been characterised by 'a feet first and fingers crossed approach' (Griffiths, 1985). The lack of any clear theoretical or organisational framework for development has led to ambiguity about the link between primary care clinical psychology and adult mental health, an uncertain situation not helped by the prevalence of yearly rolling contracts necessitated by GP fund-holding arrangements (Day and Wren 1994). The nature of the relationship between the clinical psychologist and the GP has varied depending upon local historical and political factors, for example, whether attachments were established before or after the purchaser-provider split (Brunning and Burd, 1993).

The structural and ideological changes which have impacted on public sector services in the UK since the early 1980s have led to a consideration of the psychologist's future within the NHS (Crawford, 1989). Whilst the MAS Report (Mowbray, 1989) offered a comprehensive overview of the potential breadth of the psychologist's role, the ideas and recommendations within the report were overshadowed by the subsequent NHS changes and the drive towards rationality (Childs and Jones, 1989).

The challenges facing the profession in the light of the recent NHS reforms are well documented (Pilgrim and Treacher, 1992). Pilgrim and Treacher (1992) observe that the smallness of the profession possibly limits opportunities to demonstrate that the therapeutic role is not necessarily the most cost-effective use of its broad skills base. Their commentary serves to underline the possible consequences of professional intransigence, suggesting that if the breadth of the clinical psychologist's skills base goes unrecognised, the profession may be perceived as less relevant than other mental health professionals offering significantly less expensive services.

In the light of Pilgrim and Treacher's (1992) arguments it is potentially worrying that many GPs do not know what skills the clinical psychologist can offer (Sibbald, Addington-Hall, Brenneman and Freeling, 1993). Sibbald et al. (1993) surveyed over one and a half thousand GPs nationally using postal questionnaires and telephone interviews. Their findings suggested that 30 per cent of the 95 GPs with on site clinical psychologists did not know the qualifications held by this professional. This has implications not only for development of the profession within this area but also the quality of service received by patients; it seems likely that, in the light of the GP's lack of knowledge, patients experiencing more complex psychological problems may be referred to less well trained professionals (King, Broyster, Lloyd and Horder, 1994). This raises serious ethical issues regarding the inappropriate referral of patients to professionals less able to effectively manage patients' difficulties.

Given the GP's pivotal role within the new restructured NHS the potential benefits of investigating their knowledge, perceptions and experiences of mental health services could be considered as two-fold. Firstly, it may identify how GPs could respond more

appropriately to the nature and degree of their patients' psychological needs, significantly improving the quality of patient care. Secondly, it may enable clinical psychologists to think about how, as a scarce resource within the NHS, their inimitable skills may be most effectively employed.

1.7. GPs' mental health training needs.

It seems that GPs' competencies in managing mental health problems can vary widely. Whilst some may have almost no experience or training in psychiatry or psychological medicine beyond their basic medical training, others may have undertaken psychiatric jobs during their vocational training or had years of experience as a psychiatric registrar. Some may hold the Diploma in Psychological Medicine or have other counselling or psychotherapy training (Turton, Tylee and Kerry 1995). Turton et al.'s (1995) survey of one hundred and twenty GPs suggested that hospital based psychiatric experience was often not seen as useful in the general practice context. Participating GPs reported that experience of specific mental health skills was significantly more valuable, confirming previous findings (Branthwaite, Ross, Henshaw and Davie, 1988; Mori poll, 1992).

Paradoxically, Turton et al.'s (1995) findings suggested that the majority of their sample were confident in their ability to recognise depression, whilst previous research has indicated that GPs fail to recognise half of the cases of depression presented to them (Freeling, Rao and Paykel, Sireling and Burton, 1985; Bridges and Goldberg, 1987). GPs in the sample thus requested input to help them manage patients with psychological problems, expressing less interest in diagnostic skills training.

It seems likely that GPs' perceived skills deficits will influence their use of services.

Wren (1991) reported that 15 of the 24 GPs questioned in her study stated that they referred on to a clinical psychologist because they lacked the appropriate skills to continue working with a particular client. In explicating which skills they felt they could find useful, they stated anxiety management and cognitive therapy.

Wren's (1991) study was conducted with a small number of GPs in one area. These findings, therefore, cannot be considered representative. However, the in-depth analysis offered by the study did serve to highlight the need to consider GP referrals in the context of their own experiences of psychological problems and their perceived areas of weakness.

1.8. Methodological issues: Studying the process of referral

The process by which the GP reaches a referral decision has been studied by surveying large numbers of Practitioners and their referrals to secondary care services (Morrell, Gage and Robinson, 1971; Royal College of General Practitioners, 1992). The Royal College of General Practitioners survey attempted to find significant correlations between the referral rates of over 1,500 General Practitioners from 15 European countries and a variety of practice and population characteristics. Whilst this large sample was highly representative of GPs in these countries, the study was unable to clarify important issues in this area, such as differences between high and low referring GP's and the consistency of GP referrals to different secondary services.

The first researcher to adopt a different methodological approach in this area was Dowie (1983). Using in-depth interviews with a small number of GPs, Dowie identified that professional attributes, knowledge of the health care system and personal style constituted the three principal factors influencing the referral decision. She proposed a model of the referral decision-making process derived from Janis and Mann's (1977) conflict model, in which the decision emerged as a consequence of a coping pattern used to deal with risks and uncertainties.

Dowie's (1983) study marked an important transition in the study of GP referral behaviour; the use of a qualitative methodology enabled the author to report on the importance of individual psychological factors within each decision. However, Wilkin and Smith (1987) have criticised the unrepresentative sample of referral decisions analysed by Dowie. They employed a similar qualitative method with GPs referring patients with less serious or chronic illness and have argued that a high proportion of decisions did not occur in conditions of clinical uncertainty. Wilkin and Smith (1987) thus made slight modifications to Dowie's model to ensure that it could be applied to cases where diagnosis was not uncertain.

The models offered by Dowie (1983) and Wilkin and Smith (1987) were both valuable in drawing attention to the importance of the psychological processes underlying Practitioners' referral decisions to secondary services. However, two principal criticisms could be levelled at their approach:

1) Both present the referral process as a rational progression through various sub-decisions. However, psychological research into the decision making process suggests that decisions in real life environments are not made in such a way (Tversky and Kahneman, 1981) and non-rational factors may also be important. For example, Armstrong, Fry and Armstrong (1991) showed that individual GPs tended to vary in the extent to which they perceived patient pressure suggesting that this may be an important factor in explaining differences in individual GP referral rates. Kaeser and Cooper (1971) indicated that one quarter of the referral decisions they studied were initiated by the patient or a relative. Moreover, Wren (1991) showed that, despite referring a patient to a clinical psychologist, many GPs did not expect the psychologist to be able to help. This possibly reflected the hope that the fact of referral per se may alter the doctor-patient relationship.

2) Both draw conclusions from small numbers of General Practitioners and small numbers of referral decisions. Thus, it is unclear how representative these GPs and referral decisions are in relation to practitioners and decisions more generally. For example, Dowie's (1983) model was based upon referrals to general medicine. Coulter, Noone and Goldacre's (1989) study of 18,000 referral decisions indicated considerable variation in the reasons GPs give for referrals to different specialties; for example the most frequently reported reason for referring to paediatrics was to establish a diagnosis whilst most referrals to psychiatry were made to hand over patient management.

Further qualitative work has been undertaken by Newton, Hayes and Hutchinson (1991). They interviewed 15 GPs on two separate occasions regarding recent referral decisions. Their analysis of transcripts suggested that the GPs' decisions to refer were influenced by doctor associated factors, patient associated factors, case-specific factors and structural factors. Case specific factors were related to the nature and perceived seriousness of the patient's presenting condition whilst structural factors included such things as waiting lists. Newton et al.'s (1991) work served to highlight two important issues. Firstly, it provided an explanation for why a GP might refer a patient when it does not seem necessary on clinical grounds. Secondly, it highlighted how social and cultural factors may influence the referral decision. In short, the referral decision could be considered as a consequence of the interaction between a number of rational and non-rational factors.

The interaction between different factors has been further considered by King, Bailey and Newton (1994). They interviewed 28 General Practitioners from six different districts who had recorded details of patients whom they had referred, or actively considered referring, to secondary services over a four week period. Their analysis of 167 referral decisions sought to elucidate the range of factors which may explain differences in referral behaviour. GPs were then interviewed with reference to their referrals to a broad range of specialties and transcripts were coded by a panel including a GP, psychiatrist and psychologist. Their analysis generated twenty-two higher order factors which could be grouped together in quadrants (Figure 2). Each of these factors could be considered to influence the decision to refer positively or negatively.

Figure 2. Factors influencing General Practitioners' referrals to secondary services (from King, Bailey and Newton, 1994)

A. EPISODE SPECIFIC/ CLINICAL Other management option Judgement of risk Degree of clinical certainty Symptom-related Long-term management GP/Specialist communication Time-related	B. EPISODE SPECIFIC/ NON-CLINICAL GP needs Patient feelings Patient attitudes GP/Patient communication
C. BACKGROUND / CLINICAL Lack of specialist options GP attitude Medical history Public health / resource concerns	D. BACKGROUND / NON-CLINICAL Administrative Workload Psychosocial background GP - patient relationship GP - specialist relationship GP characteristics Financial / legal

The analytical framework generated by King et al. (1994) was applied to high and low referring GP's in a subsequent study (Bailey, King and Newton, 1994). Quantitative content analysis indicated that high referring GPs were more likely to refer in response to non-clinical factors, such as the patient's wishes or to relieve their own workload, in spite of their uncertainty about treatment effectiveness. Whilst the authors acknowledge that their findings may have been an artefact of the referral decisions discussed during the interviews, their study did show how the analytical framework could be effectively used to compare broad differences in GPs' referral behaviours.

1.9. Rationale for studying GP's referrals to mental health services and research questions

Qualitative research exploring referral decisions has provided a framework which could be applied to GPs' referrals specifically to mental health services. However,

research has either studied referral data or sought to investigate the relative importance of these factors with structured interviews or questionnaires. An investigation combining audit data and interviewing would appear to be potentially productive, offering an opportunity to address the following issues:

- track the process of referral and identify factors which may influence whether or not a GP decides to refer a patient to mental health services;
- explore the relationship between these different factors;
- understand how GPs' perceptions of different services might influence their use of these services;
- place the referral process in the context of the GP's understanding of their own role and the recent changes to this role necessitated by health service reforms.

This insight may serve to enhance the effectiveness of the working relationship between the mental health professional and GP at one level, whilst, at another level, offer the providers of services an opportunity to make services more responsive to the needs of GPs and their patients.

The questions addressed by this investigation were as follows:

1. What factors influence GPs' decisions to refer patients to mental health services?
 - 1.a. Are male and female GPs influenced by different factors?
2. In what ways does the General Practitioners' experiences of mental health services influence their referral decisions?

3. In what ways do GPs' perceptions of different mental health professionals influence their referral decisions?

4. Are there gender differences in the GPs perception of their own role and does this influence the decision to refer a patient to mental health services?

1.10. Rationale for adopting a qualitative methodology.

In considering the merits of quantitative and qualitative approaches many issues could be considered. Bryman (1988) has suggested that these issues can be divided into the 'technical' and the 'epistemological'. The rationale for adopting a qualitative methodology for the purpose of this study can be considered in the light of these two areas.

Technical.

The choice of methodology is influenced by practical considerations regarding which approach is best suited to the research questions being asked. In this study a qualitative approach was considered most appropriate for the following reasons:

- the research sought to explore a complex process which might be mediated by a multiplicity of inter-related variables. There were few fixed hypotheses or predictions regarding outcome;
- it was anticipated that the participant group would be difficult to access and, consequently, in-depth interviews with a smaller sample was considered more realistic;

-previous research has indicated the relative strengths of a qualitative approach in addressing this area (Dowie,1983; Newton et al.,1991).

Epistemological.

The quantitative approach has remained the premise of the scientific method. As Henwood and Pidgeon (1995) state 'quantification is seen as the sine qua non of the natural sciences paradigm because it renders theoretical concept observable, manipulable and testable' (p115). In contrast, qualitative research seeks to extract meaning and understanding by gathering and analysing non-numeric data with reference to the context and the varying interpretations which may be placed upon it. Qualitative methods thus generate what has been termed 'dense theory' (Strauss and Corbin,1990) and is suited to studying complex psychological phenomenon. Such a method lends itself to the analysis of referral decisions; an in-depth account of the GP's own understanding of the meaning of their behaviour will take into account the context of the referral decision which has been overlooked by quantitative research.

1.10.1. The issue of generalisability

Traditional research methods have utilised measures of validity and reliability to evaluate their results. However, the epistemological issues discussed have left qualitative researchers needing to find alternative ways of demonstrating how valid and reliable the researchers interpretation and account of the participant's experience is.

Reliability/ Consistency

'Qualitative researchers can no longer beg the issue of reliability. Whilst the forte of field research will always be in its capability to sort out the validity of proposition, its results will (reasonably) go ignored minus attention to reliability. For reliability to be calculated, it is incumbent on the scientific investigator to document his or her procedure' (Kirk and Miller, 1986, p72).

As Kirk and Miller (1986) outline, in the absence of conventional reliability measures, the documentation of procedure becomes an essential part of the qualitative research process. This includes making all field notes available to the reader and explicating data analysis and interpretation. The following concepts were used in order to ensure that the reliability of the study could be gauged:

- “Auditability” (Sandelowski, 1986); this ensures that the method used is open to scrutiny and the reader is able to follow the steps taken by the researcher.

Sandelowski (1986) has argued that a study and its findings are auditable “when another researcher can clearly follow the ‘decision trail’ used by the investigator in the study” (p33). A research diary was used in order to achieve this;

- “Analytic accountability” (Henwood and Pidgeon, 1995); the process of data analysis is also open to scrutiny. In this study the processes involved in interpreting data are revealed and the subjective experiences of the researcher are presented;

- Inter-rater reliability; the reliability of the researcher’s coding of the data was gauged by comparing it with that of a second rater and producing a percentage measure of agreement.

Validity or “goodness of fit”

Quantitative studies seek to demonstrate two kinds of validity. Firstly, internal validity is achieved by demonstrating confidence that findings have ‘truth’ value and are not characteristic of the research process itself. Secondly, external validity is achieved by demonstrating the extent to which the research findings are generalisable. Guba and Lincoln (1981) have argued that qualitative research must demonstrate ‘credibility’, or

the extent to which it is a faithful and recognisable description of the participants' experiences. Also, findings should 'fit' the data from which they are derived. In this study the following concepts were used to address issues of credibility:

- Respondent Validity (Silverman, 1993); in order to ensure that the researchers interview notes provided an accurate summary of participants' accounts, notes were returned to each participant and commented on for accuracy.
- Generativity (Henwood and Pidgeon, 1995); To what extent do the research findings generate further research questions?
- Rhetorical power (Henwood and Pidgeon, 1995); To what extent does the research persuade others to accept the author's arguments and interpretations?

2. METHOD

A research diary (Appendix 1) was used throughout the study to record the authors experiences. This enables others to scrutinise the development of the study.

2.1. Ethical Approval

Ethics committee approval was obtained for the research proposal (Ethics committee letter in Appendix 2).

2.2. Design

The design of the study was comparative and correlational adopting audit and interview methodologies.

2.3. Participants

Recruitment of participants

Ten General Practitioners, 5 female and 5 male, are included in the study. Participants were recruited by sending out a standard letter (Appendix 3) outlining the aims of the research and an information sheet (Appendix 4). Practices were selected randomly from the telephone directory and 45 GPs were contacted from one health authority district. Thirty three letters were sent to GPs in a separate health authority district.

Practice managers were telephoned approximately one week after the letters and information sheets were sent and any GP expressing an interest in taking part in the study was contacted directly to discuss the possibility of arranging an interview.

Several Practice Managers requested further information regarding the project and meetings were arranged in order to provide an opportunity to discuss the research in more detail. Due to an initial poor response rate the process was repeated, sending 30 more letters to GPs in each district.

In order to ensure that two equal groups of GPs were recruited it was necessary to actively recruit two female GPs, one from each health authority district. As the telephone directory does not identify the gender of many GPs, the researcher telephoned practices randomly in order to determine the gender of the GPs. Twelve female Practitioners were identified and the recruitment procedure implemented.

Response rate

A total of 13 Practice managers indicated that a GP at their Practice had expressed an interest in participating in the study. A further two managers indicated that two GPs had expressed an interest. From these 17 GPs four subsequently reconsidered their offer to participate due to unexpected increases in workload. A further two GPs arranged times for the research interview to take place before cancelling due to crisis work. Both were unable to rearrange the cancelled interview. The final participant number of 10 represented six per cent of the total number of GPs contacted.

Summary of participant characteristics

Tables 1 and 2 summarise details regarding the five male and female participants respectively. A description of their background details is also presented¹.

Dr O'Connor, (47) is the senior partner at a large sub-urban practice, with five other practitioners, four male and one female. He has been at the same Practice for 22 years. The Practice has been fund-holding for four years. Three years ago the practice moved into a new large health centre and purchased four community psychiatric nurses offering in-practice counselling services, a behaviour therapist and a community psychiatric nurse offering a community based service. The district does not have access to a psychiatrist for adolescent problems and one of the counselling CPNs was brought in specifically to meet this need. Dr O'Connor qualified one year before the introduction of vocational training and thus did not complete a psychiatric SHO post. However, he described his medical degree as oriented towards psychiatric issues.

Dr Bannister, (43) is the senior partner in a rural based practice with three other practitioners, two male and one female. Dr Bannister has a good relationship with the head of the district psychological service, who had offered a service directly to the practice up until four years ago. The practice has been fund-holding for five years and bought in a community psychiatric nurse for several sessions per week. GPs at the practice strongly resisted pressure from the local authority to move the CPN back to a secondary care base. Dr Bannister spent six months of his vocational training as a psychiatric SHO. A significant proportion of his patients are older adults and he stated that he had extensive experience of dealing with bereaved patients.

¹ The names of all general practitioners have been changed to ensure the anonymity of participants

Table 1. Summary details of five male participant GPs.

GP pseudonym	Age	No. of years in general practice	Patient List Size	Experience in psychiatry / psychological medicine
Dr O'Connor	47	22 years	2,400	No vocational training
Dr Bannister	43	15 years	2,430	6 months psychiatric SHO post
Dr Jones	34	6 years	1,950	6 months psychiatric SHO post
Dr Allen	53	23 years	2,300	3 months psychiatric experience
Dr Peters	46	14 years	2,400	6 months psychiatric SHO post
Average	45	16 years	2,296	

Dr Jones, (34) has spent all six years of his time in general practice at the small fund-holding group practice with two other practitioners, one male and one female. The practice served a very deprived urban area. The practice bought 9 counselling sessions per week after a local FHSA research project into the effectiveness of counsellors in primary care. Dr Jones spent six months of his vocational training as a psychiatric SHO.

Dr Allen, (53) is the senior partner in a large urban practice with four other practitioners, two male and two female, including Dr Jenkins. He has been at the same fund holding practice for 23 years. The practice has been fund-holding for five years and bought in services from a behaviour therapist offering a therapeutic service as well as screening patients and advising GPs on referral to secondary services. The practice manager is a contributor to the local commissioning authority for mental health services. The practice recently purchased sessions from a local voluntary counselling service for women. Dr Allen qualified before the introduction of vocational training but acquired three months psychiatric experience as part of his medical training.

Dr Peters, (43) has been at the same sub-urban fund-holding practice for 14 years. He is one of six practitioners at the practice, five male and one female. The practice has a counsellor who works three sessions at the practice and a senior clinical psychologist had been attached to the practice for several years. This senior was replaced by a lower grade clinical psychologist but the practice found this less useful and discontinued the service. Dr Peters spent six months as a psychiatric SHO as part of his vocational training.

Table 2. Summary details of five female participant general practitioners

GP pseudonym	Age	No. of years in general practice	Patient List size	Experience in psychiatry / psychological medicine
Dr O'Sullivan	46	13	2,150	6 weeks psychiatric training
Dr Tyler	36	8	1,388	6 months psychiatric SHO post
Dr Hickson	46	4	2,000	6 months psychiatric SHO post and counselling experience
Dr Clarke	40	11	912	GP counselling course
Dr Jenkins	29	1	2,300	6 months psychiatric SHO post
Average	39	7	1,750	

Dr O'Sullivan, (46) has been in general practice for 13 years, the last eight at the same non fund-holding practice. Dr O'Sullivan is one of five practitioners at the practice, based in the centre of a large town and is the only female practitioner at the practice. The practice has an attached counsellor. Dr O'Sullivan had six weeks psychiatric training as part of her vocational training. She has also been the local GP Tutor for several years, instrumental in organising the post-graduate training programme for general practitioners, including sessions on mental health issues.

Dr Tyler, (36) has been practising at the same non fund-holding practice for eight years. The sub-urban practice contains four GPs and Dr Tyler is one of two female practitioners. A behaviour therapist has been attached to this practice for almost ten years and, more recently, a counsellor has offered several weekly sessions. Also, within the last six months, a Youth counsellor contributes one session per week. Dr Tyler spent six months of her post graduate training as a psychiatric SHO.

Dr Hickson, (46) has been in general practice for four years at the same non fund-holding practice and had previously been a teacher. She works with two male practitioners serving part of a wealthy sub-urban area. The practice has an attached counsellor offering several sessions per week. Dr Hickson spent six months as a psychiatric SHO as part of her vocational training and was also involved in informal counselling training offered by a local counsellor.

Dr Clarke, (40) is based at the same sub-urban practice as Dr Tyler. She works part-time at the practice where she has been for four years. Before this she had worked at a large city practice. She completed a GP counselling course during her vocational training and had spent one year in a training practice which had been "counselling oriented".

Dr Jenkins, (29) is based at the same practice as Dr Allen and is one of two female practitioners at the practice. Since arriving at the practice a year ago she has been responsible for the local YMCA population which involves a significant amount of work with patients with severe mental health problems. Dr Jenkins had spent time as a locum as a psychiatric SHO and her vocational training had included one session per week in psychotherapy training.

As Tables 1 and 2 indicate the average ages of the participant GPs in the two groups are broadly similar. Sixty nine per cent of GPs nationally are between the age of 35 and 54 (NHS Executive, GP Census, 1995), suggesting that the participants in this study are not grossly unrepresentative of this professional group in terms of their age. The average age of male and female GPs in England is 45 and 41 years respectively, indicating that the relatively younger average age of female participant GPs in this study reflected this tendency. The average list size for male GPs in England is also higher than the average for female GPs (2049 and 1479 respectively).

2.4. Measures

Referrals Audit Sheet

Two Referrals Audit Sheets were designed for GPs in the two different health authority districts (Appendix 5). The sheet requests the participant GP's list size before listing each individual mental health service with space provided for the number of patients referred over the previous 12 months. Services listed are based on the researcher's knowledge of local services available to GPs in each of the two districts whilst numbers of referrals to additional services, such as in-practice counsellors and private therapists is also requested. Due to the fact that fund-holding practices are able to buy non-local services, information regarding these referrals is also requested. The Audit sheet requests numbers of patients referred to the following services: psychiatry (adult); psychiatry (older adult); psychiatry (child and adolescent); clinical psychology

(adult and older adults); clinical psychology (child and adolescent); community psychiatric nurse; counsellor; behaviour therapist.

It was considered that GP referrals over the previous 12 months would provide a fairly representative sample of referrals. A longer time period may have meant that data would prove less reliable, as some Practices did not keep accessible records of past referrals to secondary services. Moreover, discussions with practice managers suggested that some fund-holding practices store referral data for each financial year on computer.

Semi-structured interview schedule

A semi-structured interview was designed for the purpose of the study (Appendix 6). Core questions within the interview are grounded in the existing literature. These are phrased as open questions to allow the respondent to raise issues which they consider to be of importance. Some authors have highlighted how the iterative nature of qualitative research allows adaptation as the research project progresses (Rubin and Rubin 1995). This allows the researcher to introduce new or different questions as more information about the area is obtained. Whilst this approach was adopted in this study, the core questions remained constant across all interviews.

The main questions included in the interview were generated by considering the existing literature in this area and could be divided into three principal areas as follows:

- Firstly, information regarding the practitioner's professional background is gathered, including their length of time in general practice and extent of their mental health training;

- Secondly, factors that the general practitioner considered influenced their decision to refer patients to specialist mental health services are explored. This is done in two ways. The participant is asked to describe a recent referral to mental health services before being asked about the various factors that they considered influenced their decision to refer. Thereafter, the participant is asked to think about their decisions to refer patients to mental health services more generally and describe factors that have influenced these decisions. GPs are asked to rank the influencing factors for both specific and general scenarios. It was considered that this approach would provide in-depth, accessible material on the one hand whilst also providing more representative information on the other.

- Thirdly, the GP is asked about his/her experiences of and feelings with regard to existing mental health services and how services might be changed or improved. This final section includes specific questions regarding his/her perceptions of mental health professionals, including clinical psychologists. The GPs' perceptions of his/her own mental health training needs are also explored.

2.5. Procedure.

Stage 1 - Audit Information

The Referrals Audit sheet was given to the GP at the time of the interview and completed either directly after the interview or left with the GP or Practice manager to be completed later along with an envelope to be forwarded to the researcher.

Stage 2 - Semi-structured Interview

Appointments were arranged with each participating GP over the telephone and a consent form (Appendix 7) was mailed to all participants before the interview. The consent form outlines the aims of the study and the GPs' rights as research participants. All interviews took place on site at the GP's Practice. The pre-interview briefing outlines the nature and aims of the research and checks that the participant has read and understood the consent form. It also assures each participant that all material remains confidential and that they and their practice remain anonymous when information is written up.

Each interview took place in the GP's own consulting room during the working day, usually between morning and afternoon surgery. The researcher chose to keep detailed notes of each interview throughout the interaction. Interviews lasted an average of 50 minutes including the time taken for debriefing. The debriefing ensures that the participants can ask any further questions regarding the research and that the interview had not raised difficult issues for them.

2.6. Data management

Audit data

The audit data collected for each participant were added together to create a total number of referrals to mental health services. In order for the referral data for GPs from both districts to be collated together, some mental health services were grouped together (e.g. child psychiatry and adolescent psychiatry). Two of the GPs (Dr Jenkins and Dr Allen) refer directly to an in-practice behaviour therapist who screens patients and advises the GP as to the most appropriate management option. This may include a

recommendation that the patient is referred to secondary services, leading to a replication of some referrals. As the practice does not have access to records showing which patients are referred twice by these GPs, referrals to the in-practice behaviour therapist and secondary services are included. This was considered appropriate given that the GP has to make two separate referral decisions. Other GPs may also refer patients to secondary services after a referral to an in-practice mental health professional and, thus, this duplication of referrals is not exceptional.

List-sizes were collected so that each GP's referral rate could be considered in the light of this. This number seems to be a poor indicator of how many patients the GP actually sees; within group practices patients sometimes choose to visit a different GP to the one whom they are registered with. However, it was felt that the list size was potentially important in indicating gross differences in the GP's allocated patient load which may influence referral rate, for example, where the GP is only working part-time.

Total numbers of referrals to all mental health services were generated for the 10 participants. Individual referral rates could then be considered in the light of these totals.

Interview data

Detailed notes were taken by the researcher during each interview and notes were then typed for each participant. (Notes from one interview are presented in Appendix 8 as an example.) Interview notes were then returned to each participant with a covering sheet requesting their feedback (Appendix 9).

Analysis of the interview notes took place in two principal stages as follows:

- categorising information relating to the referral decision making process in terms of King, Bailey and Newton's (1994) 22 higher order factors. The coding frame is presented in Appendix 10. The researcher and a second rater reviewed all ten sets of interview notes independently and inter-rater agreement was calculated for each of the higher order factors. Percentage agreement ranged from 89 to 96 per cent.

Factors were scored either positively or negatively. In order that repetition of factors did not distort these figures, a citation of a particular factor was only scored once for each participant during discussion of the recent referral decision and once again if cited during the discussion of referrals more generally. Therefore, each participant could score a maximum of two for each of the factors.

- The qualitative analysis of all interview data followed Rubin and Rubin's (1995) outline of the analysis of qualitative data. Adopted to the current study this included three principal stages of analysis:

- 1) Coding the data. Interview notes were read and reread to note core recurrent ideas or concepts linked to the research questions. These are highlighted or listed. As the notes are re-read each idea is sorted into an individual category or heading, ensuring that these preliminary categories provide a good fit to the interview data. A coding frame was developed (Appendix 11) and a second rater used the frame to analyse the interview data. Percentage agreement for the sub-categories ranged from 72 to 88 per cent.

2) Analysing material within and across categories. Examples that did not fit the categories were also highlighted to understand the meaning attached to these categories by each participant. An understanding of each theme (e.g. the doctor-patient relationship) could then be generated for each participant. Comparisons within and between groups were then made.

3) Developing an overarching theme or framework. Emerging categories were considered in the light of the research questions. Examples that fitted the categories closely were considered and examples that did not fit were also considered.

3. RESULTS

3.1. Audit information

The referral data for the male and female participant groups are presented in Tables 3 and 4 respectively.

The mean referral rate to mental health services for all participant GPs over the 12 month period was 62 (range 29-97). The mean for the five male GPs was 73 (range 51-97) and 52 for the five female GPs (range 29-93).

The variability within the sample was great and this did not seem to be related to list size; Dr Clarke, a female GP who worked part-time, referred almost as often as Dr Bannister who had the second largest list size. Two of the highest referring GPs in the sample during this one year period, Dr Jenkins (93) and Dr Allen (83), came from the same group Practice. Similarly, two of the lowest referring GPs in the

Table 3. Numbers of referrals to mental health services over a 12 month period for the five male general practitioners (List sizes in brackets).

	Dr O'Connor (2,400)	Dr Bannister (2,430)	Dr Jones (2,000)	Dr Peters (2,400)	Dr Allen (2,500)
Clinical Psychology	7	2	-	7	22
Adult/ Psychiatry	7	3	9	28	30
Older Adult Psychiatry	1	5	2	6	3
Child / Adolescent Psychiatry	2	1	9	7	5
CPN (secondary care based)	n/a	n/a	4	18	9
In-practice CPN	25	40	n/a	n/a	n/a
In-practice counsellor	18	n/a	38	31	n/a
In-practice behaviour therapist	6	n/a	n/a	n/a	14
Total	66	51	62	97	83

sample, Dr Clarke (46) and Dr Tyler (29) came from the same group practice.

The similarity between all participant GPs was the consistently high number of referrals made to in-practice mental health professionals. Four of the GPs, Dr Hickson, Dr Clarke, Dr Tyler and Dr Bannister, referred proportionately more patients to in-practice mental health professionals than to secondary services during the 12 month period. The GPs with the highest overall referral figures to mental health services, Dr Peters, Dr Allen and Dr Jenkins, also referred significant numbers of patients to in-practice mental health professionals.

Table 4. Numbers of referrals to mental health services over a twelve month period for the five female general practitioners (List sizes in brackets).

	Dr O'Sullivan (2,300)	Dr Hickson (1,975)	Dr Clarke (912)	Dr Tyler (1,388)	Dr Jenkins (2,250)
Clinical Psychology	10	-	-	-	19
Adult Psychiatry	11	5	8	3	21
Older Adult Psychiatry	2	1	-	-	4
Child / Adolescent Psychiatry	2	1	4	-	4
CPN (secondary care based)	2	6	1	1	10
In-practice CPN	n/a	n/a	n/a	n/a	n/a
In-practice counsellor	24	17	28	15	n/a
In-practice behaviour therapist	n/a	n/a	5	10	35
Private therapist	2	3	-	-	-
Total	53	33	46	29	93

3.2. Quantitative content analysis of GPs' referral decisions

Table 5 outlines the positive and negative factors influencing referral decisions of the male and female participant GPs. It shows that almost all participants cited that the nature and effects of patients' symptoms had positively influenced their decision to refer a patient to mental health services. Also, all participants noted that the extent of their experience and knowledge about general practice had positively influenced their decision to refer; this was largely related to the GP's knowledge of the availability and perceived quality of particular specialists. Several of the male and female participants

Table 5. The number of male and female GPs reporting positive and negative factors influencing their referral decisions to mental health services

<u>Episode specific / clinical factors</u>					<u>Non-clinical / episode specific</u>				
Male					Male				
+ - + -					+ - + -				
Availability or lack of options other than referral	3	1	2	1	GP's personal needs and feelings about the case	3		3	
Clinical judgement of risks associated with referral /non-referral	2		2		Patient's feelings about and/or understanding of his/her condition	2		3	
Degree of clinical uncertainty	1		4		Patient's (or family's) attitude towards referral and/or it's alternatives	2		3	
Nature and effects of symptoms	5		4						
Likely impact of referral decision on longer-term management strategy			1						
Influence of GP specialist communication	3		1						
<u>Clinical / non-specific</u>					<u>Non-clinical / background</u>				
Male					Male				
+ - + -					+ - + -				
GP's experience, knowledge and beliefs about general practice e.g. knowledge re: availability / quality	5	2	5	3	Administrative/organisational influences on referral e.g. waiting lists	2	5	1	5
Influence of patient's medical history	5		1		GP's time and work-load pressures	4		3	
					Patient's personal family and social characteristics	3		2	
					GP - patient relationship factors	3	1		4
					Financial / Legal			1	

also cited this knowledge as influencing their decision not to refer a patient to a service. Waiting lists were cited by all participants as having influenced their decision not to refer to secondary services. Finally, four male and three female participants described that pressure on their own time had influenced them to refer to a mental health professional.

Table 5 suggest two principal differences between the male and female participants. Firstly, whilst four of the female GPs cited that their decision to refer was positively influenced by their clinical uncertainty about the case, only one male GP noted this factor as an influence on their decision. Secondly, the quality of the relationship between the GP and patient was cited by four female participants as influencing their decision not to refer on to a mental health professional. In contrast, only one male participant cited the quality of the doctor-patient relationship as a negative influence whilst three indicated that it had positively influenced their decision to refer. This suggests that the quality of the GP - patient relationship was more likely to influence the female GP not to refer a patient whilst the male GP was more likely to refer because of this factor.

3.3. Qualitative analysis

The qualitative analysis of interview data generated five principal themes which are discussed below with references to quotations from the interviews.

3.3.1. GPs' perceptions regarding the relevance of different mental health professionals

The GPs' perceptions of the relevance of the psychiatrist was variable. This seemed to be related to the extent to which the GP valued an alternative medical opinion. Dr O'Connor emphasised the value of a specialist medical opinion:

".... at the end of the day the consultant provides specialist mental health expertise which for the GP is an invaluable resource...."

This assertion was developed by Dr Clarke, who explained what she considered to be the important aspects of the psychiatrist's role:

"... the psychiatrist is necessary to deal with the tip of the iceberg the most serious cases where either advice .. support .. or both are necessary..."

However, other GPs, such as Dr Jones, expressed frustration about the role of the psychiatrist, seeming to find the specialist opinion per se less valuable and somewhat superfluous:

"... I often find that I don't receive the helpful advice or follow-up I expect from the psychiatrist he may just suggest a review of the patient's medication which I can often do myself...."

Whilst Dr Jones' referral data seems to reflect his ambivalence about the role of the psychiatrist this relationship did not hold true for other GPs. Dr Peters, a relatively high referrer to psychiatric services expressed his own feelings about the unhelpful overlap between the role of the consultant and the GP:

" in many ways I think that the psychiatrist is the least relevant mental health professional they are doctors like us and work in a very similar way to what we do...."

Several of the GPs highlighted the non-medical aspect of the psychiatrists role. Dr Tyler and Dr Hickson, both relatively low referrers to this service, expressed very similar opinions:

".. the psychiatrist is important in sorting out the medical from the psychological..."

“the best psychiatrists are often good because they do more than just prescribe medication their non-medical skills are important...”

The perceived relevance of the psychiatrist thus seemed to depend upon how far the GP saw the consultant as offering something which could complement the GP's own knowledge and skills. However, these perceptions did not seem to be directly related to the GPs' use of the psychiatrist, with relatively high referrers expressing some ambivalence about the nature and extent of psychiatrists' input.

The positive comments expressed by many of the participants regarding the community psychiatric nurse appeared to relate to the flexible nature of the role which seemed to be perceived as complementing that of the GP. Dr Peters, a relatively high referrer to the secondary care based CPN service underlined the importance features of this role:

“... the CPN is the most crucial especially with regard to chronic psychiatric patients being able to provide ongoing support and ensure compliance with medications...”

However, Dr Clarke, the GP who referred least to this service also emphasised the value of the CPN's role:

“the CPN is flexible in terms of how many visits a week he can offer and can access people at home...”

There was significantly more variability in the GPs' perceptions of clinical psychologists. However, a common theme was the perception of clinical psychologists as working primarily with patients presenting with behavioural problems. Dr Peters, who had experienced direct contact with an attached clinical psychologist at his

practice and had referred to the local service within the last 12 months, expressed his ideas regarding the psychologist's remit:

"... behavioural ... obsessional problems ... eating disorders and panic attacks are the things I think would be most central to the clinical psychologists role..."

Dr Tyler, one of four participant GPs who had not referred to the clinical psychology service in the last year and had experienced limited contact with the profession, articulated a somewhat similar view:

"... there is an overlap between different professionals' skills but I think that the clinical psychologist can offer a more structured approach and stronger theoretical base than others ... this is probably most relevant to children's problems where a clear behavioural focus is valuable...."

Dr Jenkins was exceptional in offering a broader picture of the clinical psychologist's role:

".... clinical psychologists are skilled in assessment they're often able to determine which type of intervention would be most appropriate ... they offer a broad range of services such as cognitive therapy and psychotherapy..."

This broader conception of the role may have been related to Dr Jenkins increased contact with and interest in clinical psychology. Her work within the YMCA meant that her contact with all mental health services may be expected to be greater; her referral rate to the clinical psychology service was the second highest in the sample.

Also, as the youngest GP in the sample, it is possible that her vocational training placed more emphasis upon psychological issues. However, Dr Jones, another relatively young GP in the sample had no experience of clinical psychology and had rarely referred to this service at all. He expressed uncertainty about the role of the psychologist:

" there probably are differences between clinical psychologists and other professionals in terms of their skills but I'm unsure as to what these might be...."

Dr Jenkins referral rate per se may have influenced her increased awareness of the breadth of clinical psychologists' skills. However, the GP who had referred most patients to clinical psychology also had no direct experience of the profession and expressed a rather nebulous definition of the psychologist's role:

"... I think that the clinical psychologist can deal with the less serious psychiatric diagnoses anxiety ... bereavement the types of problems which people just can't get their heads round the mentally unwell rather than the mentally ill..."

It did appear that those GPs who had experienced close contact with clinical psychologists indicated an awareness of the profession's values base. Dr Bannister, who had experienced direct contact with a clinical psychologist at his practice expressed his feelings about the profession:

"... I like the ethics behind their approach it is about helping the patient to get control over their symptoms helping them to get it right themselves and taking responsibility for their own problem..."

Despite this positive appraisal of the psychological approach, Dr Bannister had not referred any patients to the clinical psychology services over the previous 12 months.

Dr O'Sullivan, who had experienced direct contact with clinical psychologists during her time as GP Tutor and had referred to the service, expressed similar sentiments:

" clinical psychologists can offer ongoing support and time to enable patients to understand problems ... rather than papering over them ... getting people to use their own resources to help themselves rather than dishing out treatment..."

In summary, perceptions of the skills of clinical psychologists varied considerably, although emphasis was often placed on the relevance of their behavioural skills to patients' difficulties. Direct contact with a clinical psychologist did appear to influence the extent of the GPs' understanding of the psychological approach. However, there

was no clear relationship between the perceived relevance of the mental health professional by the GP and their use of this particular service.

3.3.2. The inaccessibility of services

“... we often work in an unscientific way and clinical psychology could offer this ... however the trade-off is between getting this scientific assessment and getting the patient seen quickly by a mental health professional...”

Dr Tyler’s statement indicates the importance of the ‘trade off’ between referring the patient to the most appropriate mental health service and gaining access to the service when the patient requires it; regardless of how valuable a professional is perceived by the GP, accessibility of their service may be an important factor influencing the GP’s referral decision. All participant GPs highlighted the issue of the waiting times associated with secondary care based mental health services, several expressing this issue in terms of the qualitative difference between psychological distress and some physical health problems. Dr Tyler makes a general point about the nature of psychological problems in the context of waiting lists:

“... the waiting list is the principal issue.... it’s not like a hip replacement where the problem will remain stable over time...”

The implication here seems to be that patients’ psychological distress requires a rapid response because of the probability of the problem deteriorating. Dr O’Sullivan expressed her frustration at the waiting lists by highlighting the different manner in which urgent cases were responded to by services:

“..... if one of my patients were to have a heart attack I could contact a consultant on a bleep immediately the psychiatric services are too laid back ... nothing is urgent...”

The obstructive nature of waiting lists was almost universally acknowledged. In some cases this factor per se might be the principal determinant of whether or not the GP uses a particular service. Dr Clarke, one of four GPs who did not refer any patients to the clinical psychology service, suggested that the waiting list sometimes made it highly unlikely that the GP would use the service:

“..often it is not worth referring routinely to the clinical psychology department because of the six month waiting list...”

Difficulties associated with the waiting list for clinical psychology services were widely acknowledged, even by GPs who continued to refer patients to the service. For example, Dr O’Sullivan outlined some of the difficulties she had experienced when referring patients on to the waiting list:

“.... the psychology service is very good but access is very difficult patients often don’t need the service by the time they get an appointment this means a high DNA rate”

These difficulties with access seemed to be managed in three principal ways. Firstly, several GPs, including Dr Jones and Dr Clarke, described exploring alternative ways of supporting the patient without pursuing the referral:

“... with child services there is often a long wait but I tend to activate other services ... like the health visitor or the school nurse before the referral is made...”

“... I tend to find ways around the waiting lists ... like using the social services family centre ... so most of the children I refer are urgent cases and already have social services input...”

Both statements reflect a tendency for the GP to review their referral threshold in the light of waiting lists; setting this at a higher level means that only patients experiencing more urgent or severe psychological problems are referred to specialist mental health services.

Secondly, the GP may choose to refer a patient to a service in the knowledge that there is a long waiting list. Dr Allen expressed how waiting lists did not deter him from using services:

“.... I was aware of the probable waiting time but felt that you do not know about these things if you do not refer you must continue to refer in order to keep the pressure on the service...”

Dr Jenkins expressed a similar stance to this in describing how she coped with the difficulties associated with long waiting times:

“... there is a tendency to refer earlier in the knowledge that there will be a long wait whilst holding the patient yourself you can always cancel the referral...”

Dr Allen is the senior partner at the same group practice as Dr Jenkins suggesting that the similarity may reflect a practice ethos about referring to mental health services despite waiting times. Referral figures for both GPs indicate that they are two of the three highest referrers in the sample because of the number of patients they refer to secondary services. This suggests the possibility that referral rate to secondary services may be influenced by how the GP responds to the difficulties associated with long waiting lists.

The third strategy used by GPs to address the inaccessibility of secondary services related to the increased use of in-practice services. Dr Tyler developed her argument regarding the ‘trade-off’ between getting immediate mental health care for the patient and ensuring that they are seen by the professional perceived to be most appropriate:

“....referring on to an eight month waiting list involves a consideration of ethics children may require immediate attention which only in-practice services can offer...”

Dr Tyler’s relatively very low referral rate to secondary services suggests that this

consideration of ethics applies to all referrals, not just children experiencing problems; she had referred a total of four patients to all secondary mental health services in the previous year as compared to 25 referrals to in-practice professionals. This observation may be explained by the presence of an in-practice behaviour therapist, supplementing the in-practice service offered by a counsellor. Dr Clarke, based at the same group practice as Dr Tyler, highlighted the importance of having a clinician on site:

“... the waiting list for clinical psychology may influence the referral of patients with phobic type problems I feel that these patients can be seen by the on-site behaviour therapist...”

However, Dr Jenkins and Dr Allen, whose referrals to secondary services were both relatively very high, also had access to an in-practice behaviour therapist. This finding possibly underlines how the practice ethos can work in either direction, either inhibiting referrals to secondary mental health services or encouraging referrals despite long waiting lists.

Dr O'Connor and Dr Jones also suggested that the inaccessibility of psychological services was strongly influencing the GP's tendency to utilise in-practice services generally:

“... the clinical psychologist is good but the waiting list is eight to ten months we tend not to refer now because of the in-practice counsellor....”

“.... now that the clinical psychologists are all based on the other side of town ... our counsellor has become more important to us...”

These statements indicate that counsellors and clinical psychologists were also directly involved in the trade-off between the most appropriate and accessible mental health professional. However, several of the GPs noted that in-practice mental health professionals were themselves beginning to operate waiting lists, indicating that their

increased use was possibly generating demands which exceeded available resources:

“.... the counsellor provides a very good service but now has a waiting list we could do with more of her...” (Dr Jenkins)

3.3.3. The increased use of in-practice services and the stigma associated with mental health services

In the light of lengthy waiting lists, on-site mental health professionals appear to offer the GP an alternative referral option to secondary care services. However, it is also possible that the presence of in-practice services per se increases the likelihood of the GP referring a patient. Dr Jones stated this explicitly:

“.... acquiring the attached counsellor has meant an increase in the numbers of patients I refer to a mental health professional...”

This tendency to utilise accessible mental health professionals was reiterated by Dr Peters, whose referral figures suggest that he refers to the in-practice counsellor as well as, rather than instead of, secondary care services:

“...the availability of the counsellor within the practice has had an immense impact .. I now spend considerably less time dealing with the patients’ distress myself..”

This trend may be attributable to the GP’s readiness to use the on-site professional but may also be influenced by patients’ knowledge that the service is available. Dr Allen was one of several participants who emphasised how patients’ wishes may prove an important factor in how the in-practice professional is used:

“.... just as twenty years ago the patient would come in asking for valium ... now patients come in and ask me to refer them to the counsellor they come to this practice for that reason...”

However, whilst this observation may be an important one, using an in-practice professional often appeared to be a direct consequence of the GP favouring this referral option. Dr Tyler explained the benefits associated with referrals to the in-practice behaviour therapist:

“... the service is on-site it’s accessible and isn’t separated off from other parts of the patient’s life...”

This statement serves to raise the issue of the insular nature of secondary care services and the potential implications of this insularity for the patient. Several GPs referred to the ‘risks’ they perceived to be associated with referrals to secondary services. Dr Bannister had referred the highest number of patients to any one in-practice professional. In discussing referring patients to secondary care services he explained this risk:

“... referring can often be counter productive because the patient may well feel rejected and stigmatised...”

Dr Jones explained the notion of stigma when discussing how he now used the in-practice counsellor more frequently than the hospital based CPN who he had previously frequently referred to:

“.... I feel that patients find contact with the CPN more stigmatising its the psychiatric bit the name”

Several of the GPs demonstrated an awareness of the implications associated with referral to psychiatric services for the patient and this seemed to be held in mind when contemplating referral options. Dr O’Sullivan, who frequently used secondary care based services, expressed how the process of psychiatric care per se may sometimes engender dependency:

“... day care centres are a mix really it’s often difficult to get patients in and then when you do they may well get addicted to it...”

This idea was reiterated by Dr Tyler who explicated the possible consequences of this ‘addiction’ for the patient:

“ ... some patients I have referred have required brief intensive work but seem to have got stuck in the service and have become deskilled as a result...”

The possibility that referring a patient to psychiatric services may lead to stigmatisation, labelling or over dependency was not considered by all GPs. Dr O’Connor, who frequently used the broad range of in-practice services available to him, described certain non-specific benefits which may accompany a referral to secondary care services:

“.... sometimes I think that referring to the hospital makes the patient feel that they are being taken seriously that their problems have been considered important by the GP...”

This statement suggests a fundamentally different idea about the possible implications of referring a patient outside of the practice; the notion of risk to the patient is subjugated by the idea that the process of referral may serve as a communication from the GP to the patient, potentially impacting on their relationship in a positive way.

3.3.4. Proximity and communication

The increased proximity of the in-practice professional appears to offer opportunities for consultation which do not arise with professionals at the secondary care level.

Only one of the participant GPs reported consulting with a mental health professional at the secondary care level about a potential referral or to explore referral options.

However, informal advice was often sought from in-practice professionals. Dr Jenkins explained her reasons for doing this:

“.... I may sometimes consult with the CPN and counsellor in order to clarify referral options ... but I wouldn't contact the consultant I s'pose that's about availability really...”

The potential role of informal advice and communication was reiterated by many of the GPs. Dr Jones outlined what he felt would be the most helpful addition to psychiatric services:

“... some means of clarifying the situation the same day would be useful not necessarily them offering an appointment but maybe just some discussion on the telephone for example....”

In discussing his experience of mental health professional attachments to the practice in the past, Dr Peters suggested that the level of contact this had allowed had influenced the quality of the service received:

“.... two strengths of services in the past has been the CPN and clinical psychology attachments since these stopped the service has deteriorated because of the loss of direct contact....”

The GPs in the sample clearly valued opportunities for informal contact with mental health professionals which attachments allowed. Related to this sentiment was a sense of frustration regarding the poor communication between secondary services and primary care. Dr Hickson explained the nature of this difficulty:

“... sometimes I just need to find a way of opening up doors to other services ... we are supposed to be jack of all trades but often we just don't know what is available or how appropriate the service would be for the patient...”

Ideas for improving communication were also explored by both Dr Tyler and Dr Clarke:

“.... my own preconceptions regarding the expertise and interest of department is important communication with psychiatry is poor possibly due to the high turnover of staff a newsletter or information sheet might be helpful...”

“... I may deal with several consultants or CPNs and there is a need for improved liaison between psychiatric services and primary care an outreach clinic at the surgery might overcome this”

The two principal benefits of improved communication with mental health professionals outlined by GPs were two-fold. Firstly, the GP may be able to refer patients to mental health services in the light of increased knowledge regarding how the service will respond to the difficulty. Secondly, the GP may feel more empowered to manage the patients' difficulties without referring. Dr Jenkins refers to both of these when commenting negatively about the quality of the communication between her and the psychiatrist:

"... sometimes what I need most is an alternative opinion about treatment or management of the patient or some feed-back about the medications I have prescribed often I feel as if the only thing the psychiatrist can offer is a bed to the patient..."

3.3.5. Gender differences: The meanings attached to the doctor-patient relationship

In acknowledging the effect that patients had upon them, several GPs, such as Dr Peters, used the example of patients with drug problems to communicate how the GP's own feelings might influence the process of consultation:

".... I find patients with drug and alcohol problems very difficult to deal with I feel manipulated and that there is a hidden agenda of some kind..."

More generally, Dr Hickson reflected on the frustration she felt towards a patient presenting with depression:

".... I found the lady very difficult to warm to to relate to she was very frustrating and I don't feel that I was satisfying any of her needs but she was morose and depressed and my feelings may have been related to this..."

Dr O'Connor also reflected on how he had felt towards a patient who was making increasing demands upon him and how these feelings are likely to influence the GP's decision as to whether or not to refer to another professional:

" the lady was becoming a heartsink patient and my personal feelings did influence my referral decision in so far as I would not have wanted to take on any work with her...."

Both male and female GPs reflected on their sometimes ambivalent feelings towards patients experiencing mental health problems. However, the meanings attached to the doctor-patient relationship by male and female GPs did seem to be qualitatively different. Dr Jones explained how, when considering a referral, the quality of the relationship often becomes a secondary consideration in the light of competing factors such as workload:

“...often I will make a referral in the light of the knowledge that the doctor-patient relationship is a good one but time does not allow for the doctor to manage the case without referring....”

In contrast, Dr Tyler considered the issue of time expended by the GP in the context of the inimitable depth and quality of the doctor-patient relationship:

“... ten minutes counselling in the context of ten years knowledge of the patient is very different to counselling from an outsider...”

The contrast between Dr Jones’ and Dr Tyler’s statements reflects the meanings these GPs attach to the doctor-patient relationship. Whilst Dr Jones appears to suggest that a positive relationship is set against the quantity of time he could offer the patient, Dr Tyler appears to consider the quality of the relationship of paramount importance.

Dr O’Connor reported how he saw the doctor-patient relationship influencing his referral of a patient:

“..... my relationship with this lady undoubtedly influenced my decision in as much as my knowledge of her meant that I could make a more informed decision...”

Here, the relationship is considered as an important influence in so far as it offers the GP personal information which would otherwise not be available when deciding whether or not to refer. The GP does not consider the relationship in any wider sense

than this, for example, the implications of the relationship for how the patient may respond to advice or time offered by the doctor.

In contrast, even in discussing her contact with a new patient, Dr O'Sullivan considered her referral decision in the light of the developing doctor-patient relationship:

“..... I had no long-term relationship with the patient although I felt that a rapport had developed between us he trusted me and was prepared to see what I had suggested for him...”

Similarly, Dr Jenkins seemed to be considering how the doctor-patient relationship may develop when deciding whether or not to act on information from a new patient that he had a psychiatric history:

“.... he had told me something that he had not told anyone else and I therefore felt that I owed it to him to respond to this....”

The notion of patient trust was explored in some depth by both Dr Tyler and Dr O'Sullivan. This appeared to have implications in terms of when and where the patient may be referred, as in the case of Dr Tyler:

“... most patients are ambivalent about discussing their difficulties elsewhere and their trust is very important a bad experience may damage the trust they have invested in the doctor having a close relationship with the in-practice professionals means that the trust between me and the patient can be more easily maintained...”

This statement suggests that handing over the responsibility for a patient to another professional is approached cautiously, an observation confirmed by Dr Tyler's low referral rate. In contrast, Dr O'Sullivan's more extensive use of secondary services is accompanied by the adoption of certain strategies intended to manage the potential threat posed to the doctor-patient relationship. Dr O'Sullivan would sometimes go to

extreme lengths to ensure that the professional referred to would not jeopardise the trust the patient had invested in their GP:

“....There are some psychiatrists I just wouldn’t refer to ... I sometimes recommend that the patient uses a friends address to ensure that they get to see one of the better consultants.....”

In contrast Dr Allen explained his own feeling about how the relationship between GP and doctor may influence the referral:

“.. the patient may find it easier to talk openly to a stranger than with the GP who they have a long-standing relationship with....”

The contrast with other female GPs is a stark one. This statement may also reflect Dr Allen’s own lack of confidence about managing patients’ emotional distress, possibly influencing his high referral rate to primary and secondary care services.

The gender differences identified did not appear to hold for all participant GPs. Dr Bannister did recognise the threat attached to referring outside of the practice:

“... there is always a risk of something going wrong with any referral to secondary service the psychiatrist may prescribe the wrong medication for example...”

As with Dr Tyler, Dr Bannister’s own relatively low referral rate to secondary services, the lowest of all the participating male GPs, indicated that this threat may influence the frequency of referral to a mental health professional.

3.3.6. The GP’s role identity

The gender differences identified appeared to be related to how the doctor-patient relationship is understood or evaluated by the GP. It is possible that this understanding is related to the GP’s perceptions regarding their role. In other words, the importance the GP attaches to the doctor -patient relationship may be related to

the GP's perceptions of the nature and scope of their role in managing psychological problems. The issue of the extent to which GPs should acquire counselling skills served to bring this point into focus. Dr Jenkins outlined her ideas regarding the overlap between the GP and counsellor role:

“... although I am good at talking with patients I feel that I could somehow use this more effectively in-depth counselling isn't appropriate but being able to offer some short term counselling as part of the consultation would be valuable....”

The argument for broadening the role of the GP with regard to psychological difficulties was developed by Dr Tyler:

“... training in interpersonal skills ... consultation skills would be valuable ...such as how the GPs behaviour affects the patient....”

Dr Hickson communicated the views of several of the female GPs within the sample when she spoke of how she felt that her role as the only female in the group practice predisposed her to develop certain interpersonal skills:

“... I am confident in my ability to work in a non-judgmental way for example with women having termination's but some gay and lesbian patients also value this atmosphere and have used me to deal with a range of issues related to their sexuality....”

Dr Bannister, whose practice population included a large older adult population, adopted a similar tone:

“.... bereavement work is often best done by someone familiar ... family ...friends ... or someone like the GP ...”

In contrast, Dr Peters emphasised that time-constraints clearly limited the use of listening skills:

“.... I suspect that we would all benefit from more skills.... such as counselling skills but whether we'd have time to use them is another matter entirely...”

Similarly, Dr Allen perceived the GP's skills as necessarily limited:

“...patients cannot expect the GP to be an expert I have a little insight into many psychological issues but much of the GP’s work is about picking up those signals ... keeping the antennae out and picking up those things which require specialist opinion....”

The idea of the GP as a generalist was reiterated by Dr O’Connor:

“...GPs are the gatekeepers they’re there to defend health service finances and point patients in the right direction....”

However, this model was also offered by Dr Clarke whose tone differed somewhat from the other female GPs in the sample:

“... it’s not the role of the GP to counsel patients the GP’s role is to get an assessment and the most appropriate treatment for the patient on the basis of this....”

However, the risks associated with the broader role typically adopted by the female GPs in the sample were brought sharply into focus by Dr O’Sullivan, who highlighted the difficulty of reconciling her own qualities as an empathic good listener with the multiple demands of the role:

“... patients do become very over dependent on me I would like to give the patient what they want without them forming a dependent relationship on me ... finding a middle ground to protect my self...”

3.3.7. Towards an understanding of gender differences and the referral decision making process

The qualitative analysis suggests a tendency for female GPs to accept a broader definition of the GP role in relation to how patients’ psychological problems are responded to. This may predispose the female GP to attach more importance to the doctor-patient relationship, such that the possible benefits of referral are set against the potential threat to the trust and confidence which the patient has invested in them.

GPs such as Dr Allen, Dr Winter and Dr Moore explained their allegiance to a ‘signal detection’ approach to general practice work. In contrast, Dr O’Sullivan, Dr Clarke

and Dr Jenkins' presentation of their ideas about their own mental health skills indicated that their expectations of themselves in relation to their patients' distress were very different. This observation must be considered in the context of two exceptions. Dr Clarke's and Dr Bannister's understanding of the GP role seemed to be inconsistent with the relationship between gender and role identity.

The large variability in referral rates within the sample appeared to be largely attributable to how the GP responded to the inaccessibility of secondary care mental health services. High referrers to secondary services, such as Dr Jenkins, Dr Allen and Dr Peters, still utilised in-practice services but continued to refer patients in the knowledge that the waiting list would often mean long waiting times for the patient.

Low referrers to secondary services tended to perceive the waiting list as practically untenable and their response was to strategically avoid these services. In the event of multiple in-practice referral options, such as in Dr O'Connor's case, this may mean a high referral rate to in-practice professionals. However, in the case of GPs with fewer in-practice options, such as in the cases of Dr Bannister, Dr Hickson and Dr Barnard, this may result in a reliance upon a certain in-practice professional such as a counsellor or CPN. The possibility that group practices may adopt a certain strategy for managing restricted access to services was suggested by the similarities between the relatively high referring Dr Jenkins and Dr Allen and the relatively low referring Dr Tyler and Dr Clarke.

4. DISCUSSION

4.1. Evaluating the study's findings: Generativity

One means by which the findings from this study were to be evaluated was to consider the extent to which they generated further research questions. These are discussed in relation to three main areas.

4.1.1. The inaccessibility of mental health services

The extent to which waiting lists were discussed by participants indicated that this aspect of mental health service provision strongly influenced referral decisions. The importance placed upon this issue seems to reflect the high level of demand for mental health services from GPs. This demand may be related to several issues. Firstly, it may reflect the GP's lack of resources to deal with patients' psychological problems. In the light of growing pressures on time caused by increases in managerial responsibilities (Rout and Rout 1994) it is likely that GPs have less time to offer patients and are thus more likely to refer at an earlier stage. Secondly, it may be related to the greater availability of different mental health service referral options facilitated by the gradual move away from institutional forms of care towards community based services. Thirdly, it may be influenced by the patients' own wishes. This study suggested that GPs do respond to patients demands to be referred to a mental health professional and responsiveness to patients' own views has become a central tenet of recent health service initiatives (Patient's Charter, 1991).

Two important questions arise from the issue of inaccessibility. Firstly, what influences how GPs manage the problem of waiting lists and, secondly, what are the implications of this for the GPs' level of involvement in the management patients'

psychological problems? If the GP adopts a strategy of not referring patients it may mean that they take on a significantly larger psychological workload than other GPs. It is possible that these factors might influence GPs' perceptions of and confidence in their own abilities to deal with patients' psychological distress. Do GPs in areas where access to mental health services is poor perceive that management of psychological problems is an integral part of their role? Do GPs with limited access to mental health services make greater use of self-help groups and voluntary organisations than GPs with better access?

Findings from this study suggest that the GP's response to waiting lists may be influenced by a practice ethos. This finding also warrants further investigation given its possible implications for addressing GPs' referral behaviour. If low referring practices can be identified, it may be helpful to look closer at how patients difficulties are being dealt with. Does this strategy mean that patients presenting with severe psychological problems do not have access to the most appropriate care available? Alternatively, are GPs at high referring practices more likely to refer large numbers of patients inappropriately to secondary services? This study did not consider the appropriateness of GPs' referrals but this is an issue which may prove useful to consider given the variability in GPs' referral rates.

4.1.2. The influence of on-site mental health professionals and increased communication

The findings from this study suggest that the presence of on-site services may increase the number of patients seen by a mental health professional or, in terms of Goldberg

and Huxley's (1980) model, increase the number of patients seen at levels four and five. However, unlike previous research (Griffiths and Cormack, 1993) the findings suggested that the presence of an on-site counsellor did impact on GPs referrals to secondary services such as clinical psychology. As the number of on-site counsellors grows (Sibbald et al., 1993) greater numbers of GPs will have access to these services. Findings from this study suggest that the GP attaches great value to in-practice services, as reflected in the large numbers of referrals to these professionals.

This study raises the issue of what types of problems are being referred by the GP to in-practice counsellors. Some GPs underlined the benefits of on-site services in terms of increased communication and perceived relevance to the patient, emphasising the stigma often attached to secondary care services. Yet it was often unclear as to what types of patient problems would be considered inappropriate for referral to a counsellor. The possibility of severe psychological problems being inappropriately referred to on-site counsellors in the light of difficulties accessing secondary services has been highlighted by previous research (King, Broyster, Lloyd and Horder, 1994). Future research could pursue this issue by closely monitoring the type of problems referred to counsellors. Moreover, whilst counsellors will differ in their level of expertise and experience, the congruence between GPs perceptions of their skills and the counsellor's own perceptions may serve to initiate dialogue regarding the limits of the counselling role.

The current study suggests that GPs knowledge of the skills of different mental health professionals is sometimes poor, confirming previous findings (Sibbald et al., 1993).

However, GPs who had experienced close contact with certain professionals, including clinical psychologists and CPNs, had greatly valued the opportunities for informal communication and liaison which this had presented. This contrasted with the generally poor level of communication between the GP and secondary care services. Future research might explore how communication between GPs and mental health services might be improved. The use of newsletters, used to facilitate communication between some medical specialties and GPs, may help generate dialogue between secondary care based mental health services and primary care, although this may prove difficult given that mental health services are often located in separate trusts. However, such initiatives may prove extremely cost-effective given that many participants considered that improved communication may enable the GP to make more informed and appropriate referral decisions.

The GP's level of interest in mental health issues has been identified as an important factor in influencing referrals to clinical psychology (Creed et al., 1990). However, the relationship between this factor and the GP's perception of their role in relation to mental health problems remains unclear. Selecting practitioners on the basis of their level of interest in mental health issues is a difficult methodological task. However, future research could target GPs with little first hand experience of mental health professionals and monitor the effect of a mental health professional attachment upon their perceptions of their own role. Previous research has indicated that greater accessibility to certain mental health professionals reduces the amount of time the GP spends counselling patients (Warner et al., 1993). This study suggests that direct contact with clinical psychologists may influence the GP's understanding of a

psychological approach. Qualitative analysis within a longitudinal design may offer interesting insights into how new mental health professional attachments affect the quality of GPs' perceptions and decisions. It is possible that the increased level of communication associated with the introduction of an in-practice mental health professionals may facilitate finer discriminations between the skills of different mental health professionals. This may have implications for the quality of referrals received by different professionals.

4.1.3. The notion of task perception and the role of the female GP

Whilst the present study suggests that the GP's role identity or task perception (Verhaak, 1993) may influence the GP's approach to patients' psychological problems, it is unclear what the implications of this are for how the GP consults. For example, does the GP's task perception engender a certain 'closed' or 'open' consultative style (Byrne and Long, 1976)? Conversely, does the quality of the GPs consultative skills lead to increased contact with patients' psychological problems, generating a self-fulfilling prophecy, with skilled GPs assuming a greater degree of responsibility for patient distress?

The implications of these issues for the training of GPs is potentially great. It seems that many practitioners perceive their medical training as preparing them inadequately for general practice (Turton et al., 1995) and it is possible that more training in interpersonal, consultation skills may influence the GP's perceptions of their own role with regard to mental health problems and their feelings of competency in managing patients with psychological problems. Whilst research suggests that GPs manage a large

psychological workload (Shepherd et al., 1966., Verhaak, 1993) it seems that GP training places insufficient emphasis on the skills necessary to deal with this workload. An increased awareness of interpersonal processes and the extent to which the consultation can be more effectively managed may thus prove beneficial (Neighbour, 1987). Increased detection of psychological problems and enhanced patient management skills may be a consequence.

The findings also raise important questions about the role of the female GP. All the female participants in this study reported that they had acquired counselling skills during their vocational training whilst none of the male GPs reported this. This may reflect female GPs increased interest in counselling and psychological approaches, a bias reflected in the gender composition of the mental health professions. However, because the female GP is often the only female practitioner within a group practice, they may be influenced to adopt a certain role with regard to patients' mental health problems.

As patients invariably select their own GP it is possible that those experiencing psychological problems will select a female GP. Female patients, who are more likely to experience certain psychological problems because of pertinent social factors (Brown and Harris, 1978), may perceive a female GP as a potential ally, more likely to understand their difficulties than a male doctor. Also, the male GP may consider it more appropriate for the female GP to manage certain problems presented by female patients, such as problems associated with male perpetrated physical and sexual abuse.

Such possibilities suggest the need to explore the role of the female GP with a view to clarifying the expectations of patients, male colleagues and female GPs themselves.

It is also possible that the dynamics of group practices per se may necessitate one GP to take on the role of 'psychological practitioner'. Whilst a GP may have a certain interest in psychological issues and happily assume this role, the potential implications of this in terms of the GP's self-care is important. In the light of increasing numbers of GPs reporting exhaustion and high levels of stress (Chambers and Belcher, 1993), this issue would seem to be a very relevant one for the clinical psychologist to be investigating.

4.2. Respondent validity

Eight of the ten participants in the study returned the respondent validity sheet sent to them after the interview, commenting on various aspects of the content and process of the interviews. Most of the participants reflected positively on taking part in the study and two commented on how the interview had enabled them to reflect on the process of referral which they rarely had an opportunity to do. This observation must be seen in the context of the low response rate and many interested GPs feeling that they did not have enough time to do the interview. This suggests that this professional group have some difficulty identifying their own needs in the light of a large workload.

The nature of the qualitative interview was commented on in contrasting ways by two GPs. One reflected on how a structured interview may have proved a quicker way of accessing the same information, whilst another commented on how the questions

would have made no sense in the form of a questionnaire. These reflect very different attitudes towards the meanings attached to what was said during the interview. In a sense, the polarised nature of this feed-back encapsulates some of the strengths and weaknesses associated with a qualitative methodology.

4.3. Methodological issues

A qualitative methodology was chosen to investigate this area for two principal reasons. Firstly, the meanings which GPs attached to their behaviour were considered an important factor relating to how they used mental health services. Secondly, it was felt that GPs' perceptions and decisions needed to be grounded in their proper context. The qualitative approach did provide depth, offering a rich insight into the GPs' experiences. However, several methodological issues need to be addressed with regard to the qualitative methodology used in this study.

4.3.1. The sample of GPs

Three principal comments need to be made regarding the sample of GPs used in this study. Firstly, the nature of the sample means that meaningful inferences about GPs generally cannot be made on the basis of these findings. Although the 10 GPs were recruited from two different health authority districts, it is possible that regional differences in mental health service provision will influence the GP's perceptions and use of services. Recruiting GPs from a large number of very different areas may offer a more representative sample of practitioners accessing very different mental health services and responding to different pressures and influences. However, given that selection was random, it was felt that the GPs recruited for this study did vary quite

widely in terms of their ages and backgrounds and this was felt to contribute to the value of the findings.

Secondly, the low response rate of GPs suggested that self-selection bias may have been magnified in this study, with participants having a special interest in the issues being addressed. All participants had access to in-practice mental health professionals and some had experienced direct contact with clinical psychologists. The increased likelihood of GPs with on-site mental health professionals responding to investigations of the GP's use of mental health services has been observed (Sibbald, Addington-Hall, Brenneman and Freeling, 1994). However, given that the sample could be considered homogenous in view of participants' interest in mental health issues, the observed gender differences may be even more important.

Thirdly, the group of female GPs were, on average, younger than the male group and it is necessary to consider the possible implications of this. The quantitative content analysis suggested that the female GPs in the sample were more likely to refer a patient because of their uncertainty about the patient's clinical presentation. It is possible that the female GPs' relative inexperience may have influenced the finding. The qualitative analysis did not clarify the nature of this difference and it is possible that the finding is attributable to a tendency for male GPs to be less open about their uncertainty when discussing their clinical work with a male mental health professional.

However, the introduction of vocational training for GPs may be an important factor in determining the practitioners propensity to think about psychological issues at an early

stage of their professional development. Two of the male GPs in the sample had qualified before the introduction of vocational training and this may be one factor influencing the GP's role identity with regard to psychological problems. However, one of the male GPs in the sample was also significantly younger than the sample average and this factor did not seem to directly influence the GP's task perception in this case.

4.3.2. The iterative design

One important feature of the qualitative approach is the extent to which it allows the researcher to adapt the research questions as data is acquired (Rubin and Rubin, 1995). This flexibility enables the researcher to follow areas and issues relevant to their enquiry and select participants who will be able to clarify the importance of certain themes or inconsistencies. This study used follow-up questions to explore and elaborate certain themes but, due to difficulties recruiting GPs, was unable to select participants on the basis of certain characteristics, for example GPs' without access to on-site mental health professionals. This meant that this study could not pursue or test out some of the pertinent themes which emerged as the project progressed. For example, accessing a female GP practising outside of the context of a group practice may have provided data which could be compared to that provided by female GPs in group practices. This may have enabled the researcher to develop a fuller understanding of the role adopted by female GPs in the context of the group practice. This approach may have contributed greatly to the value of the findings.

4.3.3. The framework for studying GP referral decisions

King, Bailey and Newton's (1994) model for analysing GPs' referral decisions was considered a broad and robust framework which could be effectively applied to studying the GPs' use of mental health services. The quantitative content analysis enabled a comparison of male and female GPs, highlighting the role played by non-clinical factors in referral decisions which was then developed in the qualitative analysis. However, two related issues arise from use of the framework in this study. Firstly, the semi-structured interview focused the discussion on one recent referral decision to mental health services before asking the GP to consider their referrals to mental health services more generally. However, it proved significantly easier to explore the issues in relation to the recent referral question, suggesting that the specific referral decision may have been over represented. The extent to which this decision was representative of the GP referrals to mental health services is questionable.

Secondly, by using cases in which the GP deferred referral to secondary services, King, Bailey and Newton (1994) emphasised the importance of factors which influence referral decisions negatively. Although participants in this study did cite negative influencing factors, such as waiting lists, it was not possible to introduce the deferred referral scenario into the interview. Due to the time constraints it was thus only possible to explore a limited range of the GP's referral behaviour. It was felt therefore, that access to a broader range of referral behaviour would have meant that the model could have been used to better effect. Future studies may benefit from including briefer discussions of several different referral decisions and also a consideration of occasions when the GP decided not to refer.

4.4. The relationship between GP and clinical psychologist: implications for clinical psychology services

The present study indicates two important issues with regard to the relationship between the GP and clinical psychologist. Firstly, it reiterates previous findings suggesting that clinical psychologists are perceived as highly skilled and valued by GPs but inaccessible (Chadd and Svanberg, 1994). These perceptions were invariably based upon the reality of extensive waiting lists for psychological services.

Secondly, findings suggest that GPs considered the remit of the clinical psychologist to be to work with rather circumscribed patient problems, often behavioural in nature. This point has profound implications for the way in which clinical psychology services may evolve if such preconceptions continue to shape the GP's use of services. In a discussion of the problems associated with increased specialisation, Salmon (1984) addresses this issue. He argues that as a consequence of the nature of referrals received by clinical psychologists, the profession may develop an increasingly parochial perspective regarding psychological problems, losing sight of the breadth of patients' difficulties presented at the primary care level.

These two related issues seem to suggest that communication and clarification regarding the breadth of the clinical psychologist's role may increase the likelihood of their skills being appropriately used by the GP. If the GP is able to discriminate more effectively between different mental health professionals this may mean that fewer patients are referred inappropriately and 'DNAs' to psychological services are significantly reduced.

On the evidence of this study, GPs often feel disempowered by their lack of information about the skills and expertise of many mental health professionals. Moreover, it also suggests a willingness to take on board information about the skills of different mental health professionals. Using the MAS report (Mowbray, 1989) as a resource, it seems that the clinical psychologist may have much to gain from offering GPs information regarding the breadth of their training and explicating the nature of their skills.

This latter argument raises the issue of the potential benefits of closer working relationships between clinical psychologists and GPs. The possibility of clinical psychologists working in primary care settings becoming overwhelmed by the demand from GPs has been observed (Wren, 1991) and this study has reaffirmed the extensive use of on-site mental health professionals by GPs. However, unlike many other mental health professionals, the clinical psychologist can use this closer contact and increased communication in order to explore ways in which their broad skills base may be most effectively used. The potential for applying research and consultancy skills within the primary care team has been observed (Marzillier and Hall, 1992) and this may become an increasingly important feature of the clinical psychologists role as GPs demands on mental health services exceed available resources. The responsiveness of GPs and other primary care professionals' to patients' psychological distress may become an increasingly relevant area for the clinical psychologist. The focus of their work may thus broaden, with increased emphasis on the early identification of psychological problems and mental health promotion.

Whilst the NHS reforms have brought the issue of the professional identity of the clinical psychologist sharply into focus (Pilgrim and Treacher, 1992), it could be argued that a parallel process is occurring within general practice. It is possible that the variability in GP role identity which has emerged from this study may be a useful framework for thinking about the challenges facing clinical psychologists within the NHS. Working at the level of primary care may thus offer opportunities for the GP and clinical psychologist to respond to each others needs in developing a clear role identity. It may be that each has something significant to offer the other in addressing the threats and opportunities presented by the profound changes taking place within the NHS.

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APPENDICES

Appendix 1 - Research diary

Appendix 2 - Ethics Committee approval letter

Appendix 3 - Recruitment letter to general practitioners

Appendix 4 - Information sheet for participants

Appendix 5 - Audit sheets

Appendix 6 - Semi-structured interview protocol

Appendix 7 - Participant consent form

Appendix 8 - Interview summary notes

Appendix 9 - Respondent validation form

Appendix 10 - Coding frame for factors influencing the referral decision (King et al., 1994)

Appendix 11 - Qualitative analysis coding frame

APPENDIX 1.

RESEARCH DIARY

2.2.95. Generating early ideas regarding research. I want to investigate GPs' referrals to mental health services. Early in my training I had worked in an Adult service as part of a community mental health team receiving, almost exclusively, referrals from local GPs. I had conducted a service evaluation which had generated questions about the criteria used by GPs to refer their patients to the team. Several high referring GPs were contacted by the Consultant psychiatrist to provide guidelines on referring and requesting that referrals were reduced. I wonder what it was about these particular GPs that affected their referral rate: were they less confident about managing psychological problems? were they better at detecting psychological problems in their patients? did their perceptions and expectations of the CMHT influence their referral behaviour? The literature in this area is proving somewhat unsatisfying. Much of the research explores GPs perceptions of clinical psychology exclusively, taking this relationship out of the context of the range of services available to the GP. Interesting work on the consultation style offers little to explain what might influence the GP to refer a patient to mental health services. I want to investigate how factors such as the GP's consultation style and their perceptions of mental health services and different professionals influence their referral decisions.

4.4.95. First meeting with supervisor. Discuss methodology and my desire to pursue a qualitative methodology; much research in this area used consumer satisfaction questionnaires and I feel strongly that a qualitative approach has much to offer. Supervisor emphasises the issue of generalisability or transferability; would my research findings be limited to explaining the experiences or perceptions of the GPs participating in my study? How could I ensure that this was not the case? How would I access and recruit my participant group? These are sobering thoughts and I need to read more consider what my methodology will look like.

26.4.95. Corresponding with researcher in Region with experience of qualitative methods. Her letter suggests that I focus on one factor which may be important in influencing the GP's referral decision and use a comparative design. The positive feed-back on my proposal is encouraging and I think that the comparative dimension will be important. I need to clarify what factor I am going to focus on.

20.5.95. Meet with health psychologist in region. Very practical advice regarding how GPs may be accessed is very useful. I am becoming aware of how naive I am about how GPs work and how this somewhat scary adventure into the GP's world offers many possibilities. In some ways this may help me generate questions which are not influenced by a close working relationship with this professional group. I have obtained several contacts, mostly research and clinical psychologists working in primary care settings. I am beginning to think about where I will recruit GPs from.

7.7.95. Meet with trainee currently conducting qualitative research. Very encouraged by his description of his work, although feeling somewhat unfulfilled by his description of his methodology. I had hoped that the meeting would help me towards establishing how to 'do' qualitative research and as this has not happened I am becoming a little anxious about the nature of endeavour I am embarking upon. I am aware that I would feel more comfortable using a quantitative design although I am impressed by the type of data which this trainee is generating. I feel that I want to pursue a semi-structured interview in order to explore the area and questions which I am generating. My thoughts returned to validity and reliability and I need to return to the literature to explore these issues in more depth.

13.9.95. Feedback from examiners regarding research proposal. Main criticism relates to methodology and the need to explain my qualitative approach in considerably more detail. My reading around qualitative methods has made me more confident about what I have planned and I feel able to address this criticism. However, the examiner's comments to supervisor seems to question the value of investigating GPs' referral decisions. This criticism is somewhat more difficult to address! I feel that I need to present this research with this rhetorical aim in mind and I will need to be constantly aware of the "so what" question when presenting my work.

2.10.95. Presenting research ideas to year group. I am the first trainee 'up' to present a purely qualitative piece of research and feel somewhat persecuted by the response of the course staff. They suggest that I have chosen this area in order to use a qualitative method rather than tailoring my method to the area! I am also aware of how different my research ideas are to most other trainees. All other trainees appear to be researching a client group and I am questioning the relevance of my area to clinical work. Comments of course staff reiterate the importance of a comparative design.

23.10.95. Discuss feedback from presentations with supervisor. I feel that I need to introduce a model or theoretical framework relating to the referral decision. This meeting reassures me that my ideas do have clinical relevance and the 'so what' question is answerable. Feeling encouraged and wanting to pilot my interview schedule.

12.11.95. Meeting with GP Tutor. Feels that my ideas are feasible and that I should be able to access GP referral data. Recommends that I seek PGEA Approval in order to engage GPs. I feel very encouraged by his tone.

24.11.95. Met with GP to discuss my research proposal. He speaks more cautiously about my ideas and suggests that individual GPs may prove difficult to engage. Suggests that I try and look at two large group practices which will include enough

GPs for my purposes. Also sees consent to tape recording consultations as a potential obstacle to GPs participating.

19.12.95. Research group. Other trainees have ethical approval and I have yet to do this. Feeling anxious. Want to get started but feel that I still need to clarify certain fundamental issues, such as how I will access GPs and what my comparative groups may be.

5.1.96. Meeting with a local GP Tutor. We discuss the issue of how GP's age may influence utilisation of mental health services; those GPs over the age of 45 would have not had vocational training and would pick up their GP training "on the way through". Younger GPs have all experienced vocational training. He is making interesting comments about what he perceives as the main issues in the provision of mental health services to General Practice. Outlining his frustration at the FHSA who saw counsellors as more important than other professionals such as CPNs. He also explains his own uncertainty at who to refer psychological difficulties to. I feel that the discussion is hitting upon many of the issues I have touched upon in the literature and want to start interviewing GPs as soon as possible.

9.1.96. I am submitting my proposal for ethical approval. Have decided to randomly access GPs in two health authority areas and target older and younger GPs. I feel like things are moving now.

22.2.96. Feedback from ethics committee. They have highlighted that if I plan to tape consultations, I will also require patient consent and also need to go through each local ethics committee in the areas where I find GPs willing to participate. I discuss this with my supervisor and we agree that this part of the study should be dropped and I should concentrate on audit data and interviews. I feel deflated as my proposal has to go back to the chair of ethics committee and back to examiners.

28.2.96. I receive full approval from ethics committee. I can now start interviewing GPs. Relief that project is under way.

29.2.96. Mail out letters and information sheets to over 50 Gps.

2.3.96. First interview with General Practitioner. Left with impression that GP had enjoyed talking, especially regarding the process of referral. At the outset he stated that he had hoped that the interview would last about twenty minutes as he was pushed for time. However, the interview took a little over fifty minutes. Analysis of interview notes suggested two principal issues to pursue in more detail in subsequent interviews. Firstly, the GP had described how the process of referral to mental health services is often characterised as a trade-off between knowledge of waiting list constraints and the

/ GP's assessment of the severity/ possible longevity of patient's symptoms. Secondly, the value of access to informal advice from mental health professionals was reiterated throughout interview. I felt that the interview format had worked well and that the GP had felt quite comfortable with the nature and tone of the questions. He expressed positive comments about the interview and requested feedback on the outcome of the project. I am feeling relieved that the first interview has been completed and that the months of waiting are over.

15.3.96. I have received no more positive responses from 50 letters. Telephone contact with several GPs indicates that, despite appearing very interested in the study, they are worried about the length of the interview.

17.3.96. Meeting with Psychological Services Manager who is suggesting several GP Practices which may be interested in the study. I have tried these already and this adds to my growing frustration at being unable to find participants. He suggests that I may have more success if I use the Psychology Departments headed note paper and emphasise that my findings will be fed-back into the service. We re-draft a letter for this purpose. I feel encouraged by this development.

23.3.96. Another male GP agrees to participate.

27.3.96. Second interview with General Practitioner. Generally, material presented seems to underpin this GP's feelings of inexperience regarding dealing with more serious psychological problems and his uncertainty regarding the appropriateness of his referrals to services. At the end, he suggests that it would be interesting to find out what psychiatrists thought of the GP referrals they receive. This uncertainty is interesting and I am struck by his honesty. I wonder how much this GP's motivation to participate is related to this factor. He also emphasises the value of the practice counsellor and expresses dissatisfaction with the quality of input from Psychiatrist in Adult Services. He also perceives that he is less skilled in dealing with patients who abuse drugs and other substances.

2.4.96. Interview with female GP. Tone of this interview is very different. The potential offered by the doctor-patient relationship is emphasised and the GP considers referring a patient to be potentially detrimental to this. The patient's degree of trust in the doctor is a very important issue and seems to underlie this GP's extensive use of in-practice counsellors, whom she is comfortable with and knows the patient will get a "good deal". On reflection, the three GPs whom I have interviewed have all used in-practice services extensively. I feel that I need to explore the criteria used by the GP for referring beyond these professionals to specialists with a secondary care base.

3.4.96. Meeting with local Practice Manager. Had telephoned me to arrange an appointment as she was very interested in the research. Whilst encouraged, I was aware that I needed to secure appointments with GP's as soon as I could. After outlining the research aims the Practice Manager agreed to arrange appointments with two GPs at this large group Practice. Practice culture seemed very oriented towards psychological issues; had been first to secure practice counsellor and one of younger GPs covered the local YMCA population.

7.4.96. Interview with male GP. Oldest GP in my sample so far. Does not seem to perceive the doctor-patient relationship as important and the interview has a very clinical feel to it. Despite the presence of a practice counsellor there appears to be a Practice ethos that patients are referred onto lengthy waiting lists for secondary services if this is deemed necessary. Perceives self as a generalist who has no role in managing psychological problems. However, I feel quite warm towards this GP whose empathy towards the patient he described was evident. He seems to cut off from these feelings when considering his role as GP.

9.4.96. Interview with female GP from same Practice as last participant. Youngest in sample so far. Has very clear ideas about skills of different professionals although places much emphasis on the accessibility of in-practice counsellor. There seems to be a Practice ethos around referring on to waiting lists. Does consult with colleagues about patients in order to determine if referral would be best option, although this seems to be attributable to her lack of knowledge regarding patients' backgrounds and responses to previous life events.

23.4.96. No positive responses to 20 letters sent out to local GPs. Some letters and telephone calls suggested that some GPs were interested in taking part in the study but could not find the time due to staff sickness etc. This guarded enthusiasm for the project is increasing my frustration and I am now very concerned that I will not secure enough participants. Will a comparative design be possible? Will any design be possible?

24.4.96. Meeting with supervisor. Expressed my concern about the low response rate. Feeling that older GP's may be more difficult to recruit in terms of their numbers in local Practices. Decision made to recruit a half male half female sample to facilitate a comparison on the basis of gender.

1.5.96. Telephone message from female GP willing to participate. Very encouraged as the GP had contacted me directly after I had spoken to practice manager.

3.5.96. I have received several respondent validation forms back. I had not expected much feed-back but I am surprised that participants have read through notes and made useful comments and ammendments.

4.5.96. Interview with female GP. Seems very clear about the skills of different mental health professionals. Emphasis on trust, not only within doctor-patient relationship but also between doctor and professional. Felt unsure about where to refer certain patients and the availability of services. Places much emphasis on patient's own wishes. Saw her own role in managing distress as an important one. I have a sense that this role is not conducive to good self care and this GP articulates these concerns. Also asks me some advice regarding a patient which seems somewhat unboundaried but I discuss briefly with her at the end of the interview. This interview runs 25 minutes over and I leave feeling that this had been partly due to this GPs own need for reassurance about how she manages patients with psychological problems.

9.5.96. Interview with part-time female GP. Again the generalist vs. specialist distinction is made. Uses in-practice services extensively. Interview is briefly interrupted by a partner wanting to sort out several home visits. Raises issue of female GP within male based practices holding a larger psychological workload. This seems to be partly about patients (especially female) actively choosing the female GP in order to talk through problems with them but also male GPs pointing patients in this direction. Raises the issue of women working in medicine, the impact of gender roles and also the doctor-patient relationship.

11.5.95. Supervision. Discussion of the interviews conducted so far highlights the importance aspects of the process. GPs reluctant to give time to the interview often seem to use the time very constructively. Seems that GPs do not get the time to reflect on their work and the process of the consultation often gets lost as a consequence. They perceive their own mental health skills needs in terms of techniques and additional knowledge, which they are unable to use because of time pressure, rather than space to reflect and process their work. The GP contract has radically changed their time management priorities and I need to see if the research offers any description of the changes which this has involved.

13.5.96. Interview with male GP. Very rushed interview. GP had to cancel home visits in order to meet with me and I am feeling that I should not take up any more time than is necessary. Many of themes arising from interview echoed that of female GP who emphasised the potential offered by the doctor-patient relationship. Extensive use of practice based CPN despite a longstanding contact with clinical psychology department. Saw waiting list as the main problem.

24.5.96. Interview with female GP. Emphasises Practice ethos of managing patients without referral. Different type of GP; has only been in General Practice for several

years and has experience of counselling and being counselled; seems far more reflective than other participants. Despite this she emphasises her tendency to manage problems with medication rather than refer patients on to waiting lists. Whilst seemingly paradoxical, this emphasis may be a product of her own feelings about using medication to manage psychiatric / psychological problems?

30.5.96. Final interview with male GP. This was the first GP to mention cost as a factor in the referral decision. Also perceives that the process of referral can often improve doctor-patient relationship by demonstrating to the patient that the GP is taking the psychological problem seriously. May therefore refer to secondary service for this reason. Also acknowledges the importance of the personal characteristics of the professional being referred to and how well the patient will respond to this.

16.6.96. Analysing qualitative data. There does seem to be a relationship between the nature of the doctor-patient relationship and the GP's perception of their own role. This seems to underpin the gender difference which I have identified. I wonder whether this relates to the female GPs role within group practices; to what extent do patients, especially female, self select the female GP in the practice? to what extent do male GPs perceive their females colleagues as assuming this role? Gender stereotyping is important and may itself influence the types of relationship which the female GP establishes.

24.6.96. Supervision. Discuss the nature of the female GP role. The female GPs in my sample all acquired counselling experience during their vocational training. Their greater sensitivity to the doctor-patient relationship may be underpinned by this whilst the process may become self-fulfilling, with certain types of patients selecting out female GPs, and the GP developing more sensitivity to these issues throughout their professional development. Also discussed the issue of list size and how unhelpful this is when comparing referral data to mental health services. Within most group practices patients can select which doctor they see and, consequently, the list size does not reflect how many different patients the doctor may actually see.

2.7.96. Telephone conversation with practice manager regarding how I intended feeding back my data. She suggested that some forum including all GPs from the practice would be useful. I think that consulting with all practice managers and offering feed-back in this way to all participating practices may prove more helpful than information sheets. I feel that this additional effort may well prove worthwhile, as it would reach more GPs and would continue the dialogue about GPs' utilisation of mental health services.

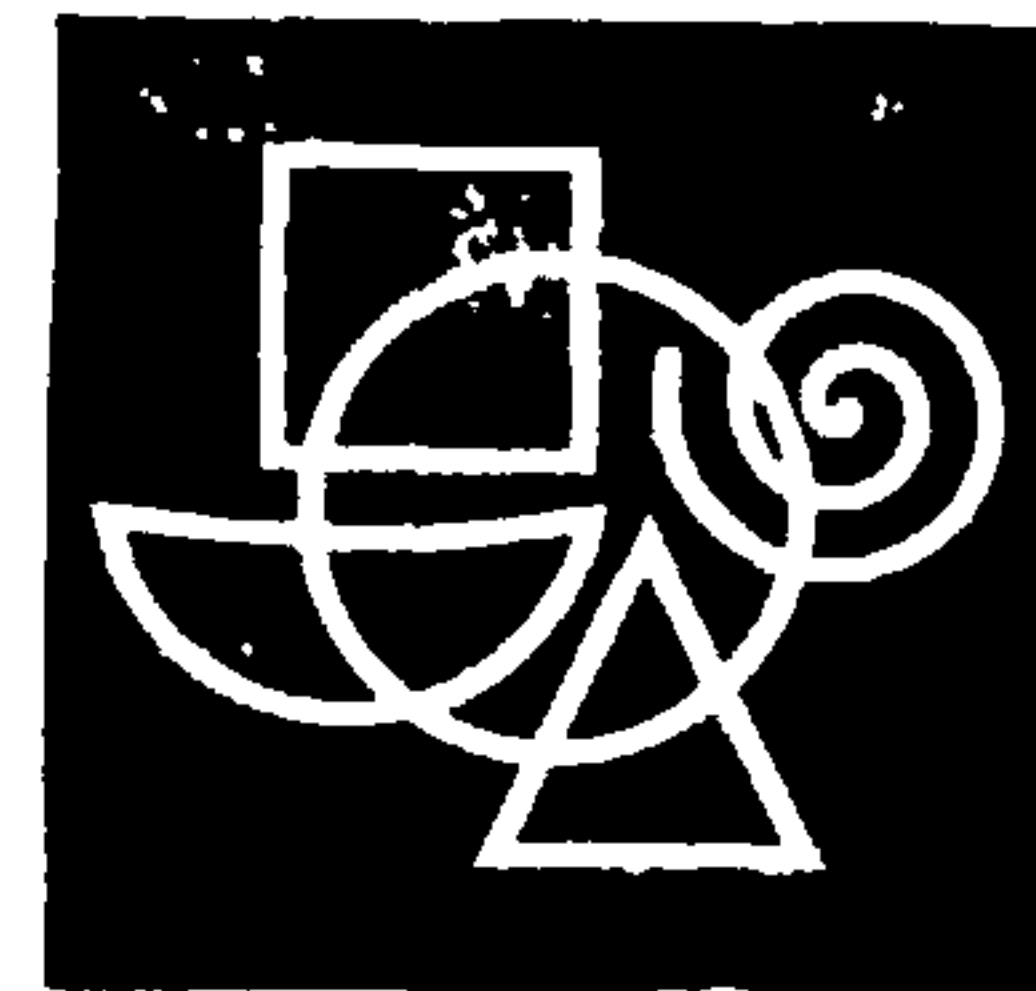
APPENDIX 2.

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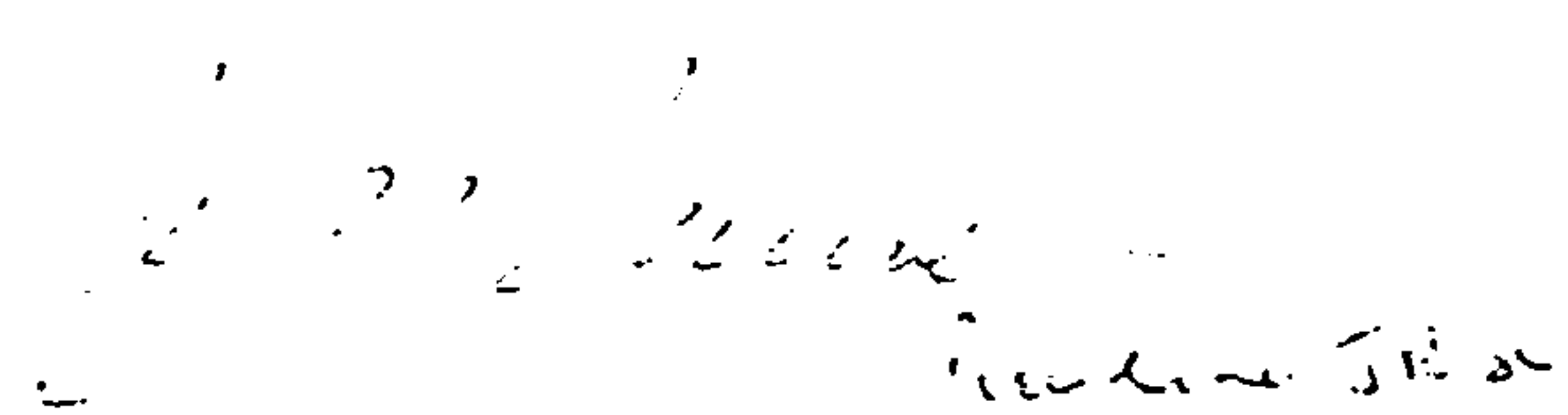
SALOMONS
CENTRE
1st March 1996

Trainee Clinical Psychologist
Salomons Centre


Dear

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were satisfied that you had taken into account the condition set and thought the proposal was also clearer. We wish you well with the project and would be very interested to see the results.

Yours sincerely,


Dr Tony Lavender
Director
Clinical Psychology
Training Scheme


Ms Anne Tofts
Director
Development Programmes


Mr Michael Maltby
Top Grade Clinical Psychologist
Weald of Kent Community
NHS Trust

APPENDIX 3.

Dear

I am hoping to gain a better understanding of how G.P.'s use local mental health and psychological services and what they think of them.

To do this I am interviewing a number of local General Practitioners and write to ask if you would take part. I appreciate that you are very pushed for time and it is an interview of fifty minutes. However, I hope that participants will find the process very useful and it will help local services respond to the needs of primary care.

My research is done in association with . I hope that results will contribute to the active debate about how mental health and clinical psychology services might best be provided.

The research will be published and participating G.P.'s will be offered a summarised feedback of the outcome.

I will be contacting all Practice Managers within the next few weeks but if you wish to contact me directly to discuss the study or take part in it, please telephone .

I look forward to speaking with you.

Yours sincerely

Psychologist in Clinical Training

cc Practice Manager

APPENDIX 4.

INFORMATION SHEET FOR GENERAL PRACTITIONERS

Making mental health services more responsive to Primary Care: An investigation of General Practitioners perceptions of and utilisation of mental health services

Research Aims:

- identify the number and nature of referrals made by participating General Practitioners to mental health services within the last 12 months;
- interview Practitioners about their experiences and feelings about these services and discuss recent referral decisions;
- facilitate a fuller understanding of the GP's perceptions of the needs of their Practice population, their expectations of different mental health professionals, and their own training needs.

What participating would involve:

- consenting to me accessing referral figures from the last 12 months;
- agreeing to an interview (approx 1 hour) at a mutually convenient time, which will be audio-taped;
- a voluntary follow-up meeting to discuss a summary of the interview.

Your rights as a research participant:

- participation is entirely voluntary and written consent will be requested;
- a right to withdraw at any stage and information will not be used;
- confidentiality of all taped information ensured;
- anonymity of all participants in the research write-up guaranteed;
- audio-tapes will be blanked following the completion of the research.

I am a psychologist in the final year of my clinical training. The research is towards the completion of my doctorate. If you are interested in finding out more please contact me on (01273) 508279. Thankyou very much.

Richard Maddicks
Psychologist in Clinical Training

APPENDIX 5.

Investigation of GPs' perceptions and utilisation of mental health services

GP's name:

GP Practice:

Please note the number of patients you have referred to the following mental health services over the past twelve months. (If any of the information is estimated please state).

Department of Clinical and Counselling Psychology:

Psychologist for Older Adults:

Child and Adolescent Mental Health Service:

Adult Psychiatrist:

Older Adult Psychiatrist:

Community Psychiatric Nurse:

In-Practice Counsellor / Behaviour therapist (please specify):

:

Other (please specify):

Investigation of GPs’ perceptions and utilisation of mental health services

GP’s name:

GP Practice:

Please note the number of patients you have referred to the following mental health services over the past twelve months. (If any of the information is estimated please state).

Adult/ Child and Adolescent/
Older Adult Psychology Department:

Adult Psychiatrist:

Older Adult Psychiatrist:

Child Psychiatrist:

Community Psychiatric Nurse:

In-Practice Counsellor / Behaviour therapist (please specify):
.....

Other (please specify):

APPENDIX 6.

Semi-structured interview protocol for General Practitioners

Participant No _____.

To be read before each interview:

- Thankyou for agreeing to take part in this research investigating GP's experiences of mental health services and the factors influencing their decision to refer patients to these services. It aims to look at your beliefs and feelings about these services and also the process of referral by discussing referral decisions. I hope that you find it helpful to consider these issues. As I have already mentioned I am a psychologist in my final year of clinical training and will be writing this research up as my dissertation. I hope that it will provide information which is of value to both General Practitioners and mental health professionals.

- Before we start the interview I would like to check that you have read the consent form and give you an opportunity to ask any questions about the research. I will then ask you to formally give consent to the interview. I would like to remind you that you can withdraw from the interview at any stage and I will not use any of the information you have given me. Also, any information used in the write-up will be presented in such a way that it protects your identity. I would like to tape record the interview with your permission. All tape recorded data will be destroyed at the end of the project.

Date of Interview _____.

Time interview begins _____.

1. Background Information

I would like to begin by finding out some background information about you as a General Practitioner and your previous experience of mental health services.

i) How old are you and how long have you been a General Practitioner?

ii) How long have you been working at this Practice?

iii) Is the Practice fund-holding?

iv) Could you briefly outline any training you have received in psychiatry or psychological medicine. (This may also include education in mental health issues,

experience such as a psychiatric post during vocational training, psychiatric registrar etc).

v) In percentage terms, what would consider to be the average GP referral rate to mental health services?

vi) Would you estimate that the number of referrals you make to mental health services is above, below or the same as, this average?

vii) Could you describe the range of mental health services available to you and the Practice at present (including counsellors).

viii) How has this changed since you have been at the Practice?

2. Factors Influencing Utilisation of Mental Health Services

I would now like to discuss factors which you consider have been important in influencing your decisions to refer patients to mental health services.

1) I would like you to think about the most recent occasion when you have referred a patient to specialist mental health services. Who did you refer to and what do you consider was the principle factor influencing your decision to refer?

Clinical factors

i) To what extent do you think that your assessment of the patient's symptoms influenced the decision?

ii) How far do you think that the patient's medical history influenced your decision?

iii) How far do you think that your perception of treatment effectiveness influenced your decision?

iv) To what extent do you think that your consideration of the quality of the specialist services available to you influenced your decision?

v) Did consultation with another colleague or mental health professional influence your decision?

Non-clinical

- i) How far do you think that your decision was influenced by your own feelings about the patient?
- ii) Do you consider that your relationship with the patient influenced your decision?
- iii) To what extent do you think that your decision was influenced by the feelings or views of the patient?
- iv) How far do you think that consideration of your own workload influenced the decision?
- v) Do you think that consideration of the limits of local services e.g. waiting lists influences your decision?
- vi) How important were financial issues in influencing your decision to refer?
- vii) If you had to rank the principle factors influencing this particular referral decision what would they be?

General

- i) I'd like to think more generally about other recent occasions when you have referred patients to mental health services. Do you think there are factors which influenced these other referral decisions which have not yet been discussed?
- ii) If yes, what are these factors?
- iii) If you had to rank the principle factors influencing your decisions more generally what would they be?

3. Experiences of using services/ perceived service deficiencies

- i) What has been your experience of using mental health services?
- ii) If you were able to reorganise mental health services to meet your patients needs more effectively, what would you change?
- iii) Which mental health professionals do you consider to be most relevant to the needs of your patients?

iii) Which mental health professionals do you consider least relevant?

4. Perceptions of Clinical Psychologists

i) Have you ever referred to a Clinical Psychologist?

ii) Have you had any other contact with a Clinical Psychologist e.g. liason regarding a case, teaching etc)

iii) What do think the Clinical Psychologist has to offer your patients or Practice?

vii) Do you think that the Clinical Psychologist is able to offer anything additional to or different from other mental health professionals?

5. Own mental health training needs

vi) Are there any mental health skills which you feel most confident about?

vii) Are there any skills which you consider least confident about?

vii) Do you think that you would benefit from training in these areas?

6. Debriefing

To be read out after each interview:

I would like to thank you for taking the time to take part in this interview. I will be looking at the information which you and other General Practitioners have given me to look for areas of commonality and difference.

- Do you have any questions about how I will be using the information?

- Has taking part in the interview raised any particular difficulties or issues for you?

If there are any other issues arising from the research which you have further questions about you will be able to contact me on (01444) 441881 extension 4706.

I would like to send a summary sheet of the interview and of my understanding of the information you have provided today. If you would like to receive this please tell me.

If you would like an opportunity to discuss this summary or the interview itself in more detail I would be very happy to arrange a time to do this.

Time interview ends:_____.

APPENDIX 7.

CONSENT FORM

An investigation of General Practitioners perceptions of and utilisation of mental health services.

Researcher: Richard Maddicks, Psychologist in Clinical Training

Research outline: This research attempts to investigate:

- the number of referrals made by General Practitioners to mental health services within the last 12 months;
- the GP's experiences of using mental health services;
- the factors which GPs consider influence their decision to refer a patient to mental health services.

What taking part will involve:

This will involve consenting to two things:

- Firstly, I will access available information regarding numbers of referrals to mental health services.
- Secondly, a face-to-face interview, taking approximately forty five minutes, will take place with myself which will also be audio-taped. Questions will centre on your own experiences and thoughts regarding referring patients mental health services.

All information will remain confidential, your anonymity will be ensured when the work is written up and all audio-taped material will be blanked following completion of the research.

I (Name)

of (Address)

..... (Telephone contact)

consent to take part in the above research. I have been given information about the nature and purpose of the research which I have read and understood and can keep for further reference. I have asked any questions I wanted to about the research and these have been clearly and satisfactorily answered.

Signed Date

APPENDIX 8.

Interview Summary - Participant 3

Background Information

Age: 36

Principal GP since 1988 at the same non-fundholding practice

Six month psychiatric training as part of vocational training. Also has been involved in 'a lot' of post-graduate psychiatric training e.g. psycho-sexual medicine

Estimated average GP referral rate to mental health services as 'very tiny'. Point nought something as a percentage of all their referrals

Estimated her own referral rate to mental health services to be less than this average inclusive of referrals to counsellor, behaviour therapist etc.

Services available: Practice counsellor (1 session per week) for last 18 months, behaviour therapist (1 session) last 10-12 years, Youth Advisory Centre (1 session per week) for approx. last 6 months, Adult Psychiatry, Psychology, Older Adults Service, Child and Adolescent Psychiatric Services

Factors influencing referral

Most recent referral. Lady in 50's with long-standing arachniphobic difficulty. Had experienced contact with behaviour therapist in the past. Patient requested to see therapist again.

- Re-referral was entirely appropriate from clinical point of view. The patient's phobia had worsened in relation to life events and her level of depression
- Awareness that behaviour therapist was effective in managing/treating phobic problems
- Discussed case with behaviour therapist but this did not influence decision to refer. Also wrote formal referral letter
- personal feelings not involved
- ongoing relationship with patient is important but a patient would not be referred as a means of maintaining this.

- workload did not influence this referral
- financial considerations did not influence this referral

ranking of principal factors influencing this referral decision:

- probability of success or a positive 'result';
- what the patient wanted.

Ranking of factors influencing referral decisions to mental health services in general

1. Waiting lists are principal consideration when referring outside of Practice. Decision whether or not to refer a patient to a service with a long waiting list (e.g. 8 months plus for adult psychotherapy) involves a consideration of ethics. Children may require immediate attention which only in-Practice services can offer. Have in the past referred outside of Practice but provided counselling during the waiting period
2. Knowledge of quality of professional at the other end. Refers where she knows patient will get 'a good deal'. Some patients would be referred anyway e.g. for diagnostic assessment. However, most patients with difficulties are ambivalent about discussing them elsewhere and patient's trust is very important i.e. bad experience may damage trust invested in doctor. May not refer patient to most appropriate professional if there are any doubts about professional. "Ten minutes counselling in the context of ten years knowledge is very different to counselling from an outsider"
3. Own preconceptions as to the skills/expertise/interests of departments influences referral. Interaction flow from Psychiatry is poor (due to high turnover of staff?). Newsletter or some information may help
4. In light of factors 1-3, rarely refers outside of Practice. Considers that patients with depressed/neurotic illnesses are "better dealt with here"

Experiences of Mental Health Services

In-Practice services are excellent e.g. behaviour therapy

Psychiatrist for Elderly responds quickly to referrals and sees patients in their own home. Good summary and opinion provided and appropriate referral on where necessary

Have not used Psychology/Psychotherapy services and thus can not comment

Child and Adolescent Psychiatry has got much better i.e. providing clear assessment and appropriate treatment (“certainty and clarity is often what is needed most from a referral”)

Adult Psychiatry often not used much but variable when used e.g. in terms of follow-up and sectioning. Some patients referred have required brief, intensive work but seem to have got ‘stuck’ in the service and consequently have been de-skilled

Very little experience of CPNs

Changes to services

Professional esp. Psychiatrist in Adult service responding to what GP wants from referral e.g. one off management advice rather than referral on. some patients require intensive “getting back on their feet type work” e.g. life-skills, but psychiatry can still be “mucking about” over one year later. Feels very frustrating

Perceptions of professionals

Consultant Psychiatrist important for providing medical opinion and “sorting out” the medical from the psychological

Behaviour therapist offers a brief service relevant to many patients’ needs. Service is also on-site, accessible and thus is not separated off from other parts of the patient’s life. Having immediate access to a ‘proven’ service is extremely relevant as patients may find it easier to talk through problems at this point and trust between doctor and patient can be more easily maintained

Perceives a role for good CPN service to access housebound patients. Experience of this has been “patchy” with regard to Adults. CPNs in service for Elderly are extremely relevant

Least relevant professionals:

Psychotherapist. Have to wait one year on waiting list then the treatment is very long and intensive. Not relevant given the extent of psychological problems in the population

Psychology. Waiting list again is principal issue. “It is not like a hip replacement where the problem will remain relatively stable over the waiting time”

Perceptions of Clinical Psychologists

Has referred to clinical psychologist

Involved in some training re: management of eating disorders run by a clinical psychologist

Although many of their skills overlap with those of other mental health professionals, Clinical Psychologist can offer a more structured approach and stronger theoretical base than others e.g. counsellors

Structured approach may prove extremely relevant to all patients but especially children's problems where a clear theoretical / behavioural focus is necessary

Could be more involved in diagnostic / assessment work. GP often works in an unscientific way and clinical psychologist can offer a scientific view re: diagnosis and severity. However, the trade-off is often between getting this scientific assessment vs. getting patient seen quickly by a mental health professional

Mental Health Training Needs

Strengths:

Fairly confident about diagnostic / assessment work

Confident about ability to work in a containing, non-judgmental way with vulnerable patients e.g. depressed. Has patients who are gay and lesbian who value this safety and have been able to use relationship with GP to deal with a range of issues related to their sexuality

Weaknesses and areas of least confidence:

dealing with violent patients (although feels that she is quite good at this)

not very skilled at dealing with drug related problems. Partly through choice (not wanting to invite the problems associated with prescribing methadone e.g. boundaries around GP's role and increased work load) and partly through nature of Practice population

Mental health training needs

people management skills e.g. violent patients

training in drug related problems would not be useful as these patients are not being taken on but there is possibly scope for improving skills and taking more of these problems on

Generally, training should be tailored to GP's existing skills which is variable. there is often little recognition from Psychiatry of the psychological workload managed by GPs

Training in interpersonal, consultation skills would be valuable e.g. how GP behaviour affects patient

Stress management and self-care for GP's is very relevant to how effective the GP consults (almost one quarter of GP's are depressed and thus do not consult effectively). maybe some formalised support for GP's would be helpful to encourage GP's to communicate their difficulties

Psychologist in Clinical Training

16.5.96

APPENDIX 9.

PLEASE RETURN IN PRE-PAID ENVELOPE

Dear

Re: Research into GP's utilisation of and perceptions of mental health services

Thankyou very much for participating in the research into GP' utilisation of and perceptions of local mental health services. I would be very grateful if you would read the attached summary. If there are any additions, amendments or other comments which you would like to make about it please do so on the summary or in the space below.

Do you have any positive feelings or thoughts regarding the interview? (These may be related to the content of the interview or the process of taking part).

Do you have any negative feelings or thoughts regarding the interview?

Are there any other comments you would like to make?

If you would like to receive a feed-back sheet regarding the outcome of the project please tick here:

If there are any other issues arising from the interview which you would like to discuss please contact me on . Thankyou again for participating in the research. I hope very much that this has been a useful experience.

Mr
Psychologist in Clinical Training

APPENDIX 10.

FACTORS INFLUENCING REFERRAL - Coding Frame (King,Bailey and Newton,1984)

1. CLINICAL / CASE-SPECIFIC

a) Availability or lack of options other than referral

- GP skills (knowledge,experience,confidence)in this case
- Treatment or management option availability
- Facilities/services in practice
- Other specific options failed

b) Clinical judgement of risks associated with referral/non-referral

- Risks associated with condition
- Risks associated with treatment/investigations
- Consideration of side-effects of specific treatments

c) Uncertainty

- Clinical uncertainty
 - a. about diagnosis
 - b. about history
 - c. about treatment/investigation/management effectiveness
- GP suspects psychosomatic element to problem
- Need to exclude physical cause
- Specialist may not accept referral

d) Nature and effects of symptoms

- Severity/lack of severity of symptoms
- Pattern of symptoms
- Duration of symptoms
- Physical effects of condition in patient's life
- Psychological effects of condition in patient's life
- Pain/discomfort caused by condition
- Cosmetic concerns

e) Likely impact or referral decision on long term management strategy

- Referral as instrumental in achieving longer-term goals
(ie.where referral is not useful in itself)
- Referral may distract from GP's management plan

f) Influence of GP-Specialist communication about the case

- Opinions/advice of other health professionals to GP
- Referral to communicate with Specialists
- Opinions/advice of other health professionals to patient

g) Possibilities of postponement of referral decision

- Nature of case/condition makes review possible
- Further information needed from hospital before referral
- Long-term possibility of advances in medical techniques

2. NON-CLINICAL/ CASE-SPECIFIC

a) GP's personal needs and feelings about the case

- GP's frustration about the case
- GP's need to "do something"
- GP's anxiety about the case
- GP's emotional response to the case
- GP's personal need to know "what's happening"
- GP has managed patient without need for referral up to now
- GP's feeling of being manipulated

b) Patient's feelings about and/or understanding of his/her condition

- Patient's understanding of his/her condition
 - a. Physical condition
 - b. Psychological/psychiatric condition
- Patient's feelings of frustration with the case
- Patient's anxiety about condition

c) Patient's (or family's) attitude towards referral and/or its alternatives

- Patient(or family) requesting or demanding referral
- Patient's(or family's) reaction to GP's suggestion of referral
- Patient's reaction towards specific treatment
- Patient's(or family's) dissatisfaction with previous advice
- Patient's(or family's) attitude towards alternative options
- Carer(s) no longer able to cope

d) Effects of GP - patient communication quality

- Quality of communication during consultation
- GP and patient have different agendas

3. CLINICAL/NON-SPECIFIC

a) Lack of Specialist Options

- Lack of availability of particular specialist service
- Lack of availability of particular treatment

b) GP's experience, knowledge and beliefs about General Practice

- GP's knowledge of accepted normal practice
- GP's knowledge and experience of speciality
- GP's overall confidence in own ability
- GP's personal experience of specific comparable case(s)
- Experience of comparable cases within the practice

- GP's anecdotal knowledge of comparable case(s)
- GP's personal beliefs about what constitutes "good practice"
- GP's personal beliefs about what a GP's role should be
- GP's personal beliefs about patients in general
- GP's personal beliefs about NHS
- GP's knowledge of the Health Service
 - a. Knowledge of particular Specialists
 - b. Knowledge about service (availability, quality)

c) Influence of patient's medical history

- Patient's previous history of same/similar condition
- Patient's family history of same/similar condition
- Patient's history of other conditions

d) GP's NHS resource and Public Health concerns

- Concern for appropriate use of health service resources
- Public health concerns

4. NON-CLINICAL/NON-SPECIFIC

a) Administrative/organisational influences on referral

- Administrative/organisational requirement for GP referral
(e.g. re-referral when patient has missed follow-up; request from optician or other para-medical; initial referral letter "lost")
- Waiting concerns (appointments, lists)
- Contractual/organisational problems in referral

b) GP's time and workload pressures

c) Patient's personal, family and social characteristics

- Patient's social/family circumstances
- Patient's knowledge of NHS
- Patient's personality (stable/enduring characteristics)
- Patient in private insurance scheme

d) GP-patient relationship factors

- GP's expectations based on knowledge of the patient
- Concern to protect/establish relationship
- Concern for GP/practice reputation with patient/family
- Patient's/family's trust in GP
- Quality of GP-patient relationship
- GP's need to relieve burden of care ("Heartsink" patient)
- Concerns for patient's future use of the practice

e) GP's concern for relationship with Specialist

- Concern to protect/develop relationship
- Concern for GP/practice reputation with specialist

g) Financial and legal considerations

Financial costs/rewards of referring/not referring

Medico-legal concerns re case

APPENDIX 11.

Themes emerging from qualitative analysis - coding frame

1 GPs experiences of mental health services

- a) Accessibility: i) waiting times ii) location
- b) Confidence in mental health services
- c) communication with mental health services
- d) stigma and labelling

2 GPs perceptions of different mental health services

- a) relevance of services
- b) differentiation between professionals

3 Interpersonal factors

- a) the doctor-patient relationship
- b) the process of consultation

4 The interface between the GP and mental health services

- a) the relationship between the GP and mental health professionals
- b) GPs' perceptions of their own role in managing patients' mental health problems
- c) GPs' referral threshold

Definitions for coding

1 a) i) waiting times: a negative, positive or neutral comment regarding the waiting time involved when referring to a mental health professional or service (e.g. waiting list, general response time)

1 a) ii) location: a negative, positive or neutral comment relating to the physical location / base of a mental health professional or service

1 b) confidence in mental health services: a negative, positive or neutral comment expressing how confident the GP feels about using a mental health professional or service

1 c) communication with mental health services: a negative, positive or neutral comment regarding the communication between the GP and a mental health professional or service (e.g. liaison, consultation, informal or formal)

1 d) ii) stigma and labelling: a comment relating to the negative social perceptions or anticipated negative social perceptions associated with a patient using a mental health service

2 a) relevance of services: comments relating to the perceived relevance of the specific skills or role offered by a mental health professionals or service

2 b) differentiation between professionals: a comment distinguishing between mental health professionals or services on the basis of the skills or roles which they offer

3 a) the doctor-patient relationship: a negative, positive or neutral comment regarding the general nature of the relationship between the GP and their patient

3 b) the process of the consultation: a negative, positive or neutral comment regarding the specific consultation with the patient (e.g. consultation skills, communication within the consultation)

4 a) the relationship between the GP and the mental health professional: a negative, positive or neutral comment about the professional relationship between the GP and mental health professional (e.g. role differences and overlap, disagreement)

4 b) GPs' perceptions of their own role in managing patients' mental health problems: a comment regarding the GP's perceptions of the nature and extent of their role in managing or treating psychiatric / psychological problems

4 c) The GP's referral threshold: a comment relating specifically to where the GP perceives the cut-off point between holding or referring a patient with a mental health problem (e.g. general or episode-specific criteria used to evaluate a patients difficulty)